Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Louisiana** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Adult Day Health Care (ADHC) Waiver

C. Waiver Number:LA.0121
Original Base Waiver Number: LA.0121.90

D. Amendment Number:LA.0121.R07.01

E. Proposed Effective Date: (mm/dd/yy)

12/01/18

Approved Effective Date: 12/01/18
Approved Effective Date of Waiver being Amended: 07/01/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Changes in this amendment include:
- Modified priority group #3 for waiver offers to establish that priority will be given to those individuals admitted to (or residing in) a nursing facility who have Medicaid as the sole payer source for the nursing facility stay, with the intent that they be discharged to the community.
- Updated Level of Care to reflect changes to the Behavior pathway for new applicants. (This change will not impact eligibility of those currently in the waiver who initially met, and continue to meet, Level of Care on behavior pathway only; nor will this change impact services provided to these individuals.
- Modify Transition Intensive Support Coordination (TISC) service definition to clarify the time frame of "6 months" (no more than 180 calendar days)
- Align Appendices A & I QIS measures with the Community Choices Waiver(LA.0866.R01.03)amendment effective 7/1/18.
- Update Appendix B-5 per CMS recommendations in the Community Choices Waiver(LA.0866.R01.03)amendment effective 7/1/18.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following

component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☒ **Appendix A Waiver Administration and Operation**	QI
☒ **Appendix B Participant Access and Eligibility**	B-3.f; B-5.e-g B-6.d
☒ **Appendix C Participant Services**	C-1/3-TISC
☐ **Appendix D Participant Centered Service Planning and Delivery**	
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	
☐ **Appendix G Participant Safeguards**	
☐ **Appendix H**	
☒ **Appendix I Financial Accountability**	QI
☐ **Appendix J Cost-Neutrality Demonstration**	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Modify priority waiver group and level of care criteria.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Louisiana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Adult Day Health Care (ADHC) Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: LA.0121
Waiver Number:LA.0121.R07.01
Draft ID: LA.004.07.01

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/17
Approved Effective Date of Waiver being Amended: 07/01/17

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Adult Day Health Care (ADHC) Waiver, a 1915(c) waiver, is designed to enhance the home and community-based services available to individuals who would otherwise require care in a nursing facility.

The goals and objectives of the ADHC Waiver will be as follows:

GOALS

1. To provide home and community-based services to individuals age 65 and older who are Medicaid eligible and meet nursing
   facility level of care; and adults with physical disabilities age 22 to 64 who are disabled according to Medicaid standards or SSI disability criteria, Medicaid eligible, and meet nursing facility level of care;
2. To promote participants' freedom to make choices in their lives;
3. To promote participants' self-determination in exercising control over how, where, and with whom they live;
4. To ensure participants' health and welfare;
5. To ensure that participants have the support and assistance desired to care for themselves and engage in the community;
6. To promote participants' self-determination in identifying appropriate supports and/or services; and
7. To enhance participants' informal supports.

OBJECTIVES

1. To implement a Quality Improvement Strategy (QIS) to ensure the health and welfare of participants;
2. To allow participants choice in selecting providers and support coordination agencies through the Freedom of Choice process;
3. To develop an individualized, person centered plan of care that embraces participants' self-determination and which is responsive to the participants' needs and preferences;
4. To allow participants the choice between institutional care and home and community-based services; and
5. To ensure that only qualified providers and support coordination agencies will serve participants.

The Louisiana Department of Health and Hospitals (DHH) is the cabinet-level "umbrella" agency for the major publicly-funded health and long term care programs in Louisiana. The administering, operating, and licensing agencies for the ADHC Waiver are located within DHH. Within DHH, the Bureau of Health Services Financing (BHSF) is responsible for the administration of the state Medicaid program and is the administering agency for the ADHC Waiver. The Office of Aging and Adult Services (OAAS) serves as the operating agency for the ADHC Waiver and is the policy and program agency for older adults and people with adult-onset disabilities. The Health Standards Section (HSS) serves as the licensing agency for the state and is responsible for the licensing and oversight of ADHC providers. All agencies reporting to the same cabinet Secretary enables close collaboration, coordination, and oversight.

Sections within BHSF are responsible for provider enrollment, determination of rate setting, claims payment/management, fraud prevention/discovery/remediation, and monitoring of OAAS as the Operating Agency for the ADHC Waiver. BHSF and OAAS serve jointly as contract monitors for the point of entry contractor.

OAAS operates the ADHC Waiver through its three divisions for Policy, Research & Quality, and Program Operations; and through its nine regional offices. The ADHC Waiver is accessed through the OAAS single point of entry contractor and the Louisiana Options in Long Term Care Help Line. When criteria are met, the individual's name is placed on the ADHC Request for Services Registry (RFSR) until a waiver offer becomes available. When the individual is offered the ADHC Waiver, he/she may accept or deny the offer. If the individual accepts the offer, he/she chooses a support coordination agency through the Freedom of Choice (FOC) process. The support coordination agency then offers FOC of provider(s). Once the individual is found eligible for waiver services, OAAS or its designee must approve the individual's plan of care (POC). All services must be prior authorized and delivered in accordance with the approved POC.

The ADHC Waiver employs the traditional service delivery method while promoting self-determination principles for our population to maintain as much independence and control over their lives as feasible.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide

individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

In accordance with 42 CFR 441.304, the State's intention to amend the ADHC Waiver application and a summary description of changes were published in eight major Louisiana newspapers on July 25, 2018. The entire waiver application was also made available on the OAAS website for public review and comments for a period of 30 days prior to the submission to CMS for approval. The public comment period was July 25, 2018 through August 24, 2018.

The Department's public notice and input processes for this amendment consisted of the following:
1. The State published the public notice in the 8 major daily newspapers of the State with the largest circulation. They were published in the following cities: Lafayette, Baton Rouge, New Orleans, Alexandria, Shreveport, Monroe, Lake Charles, and Houma. The public notice appeared in the Legal Ad Section of the hard copy newspapers and was published electronically on the Louisiana Press Association website. Within the public notice, we provided information on how to access the waiver application and provide comments and feed back in both hard copy and electronic forms. The following language appeared in the public notice:
"The Louisiana Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services (OAAS) currently provide home and community-based services through the Adult Day Health Care (ADHC) Waiver to eligible Medicaid recipients.
The department hereby gives public notice of its intent to seek approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to amend the ADHC Waiver in order to:

- Modify priority group #3 for waiver offers to establish that priority will be given to those individuals admitted to (or residing in) a nursing facility who have Medicaid as the sole payer source.

- Modify Transition Intensive Support Coordination (TISC) service definition to clarify the time frame of "6 months" instead of "180 days"

- Update Level of Care to reflect changes to the Behavior pathway for new applicants. (This change will not impact eligibility of those currently in the waiver who initially met, and continue to meet, Level of Care on behavior pathway only; nor will this change impact services provided to these individuals)

- Align Appendices A & I QIS measures with the Community Choices Waiver(LA.0866.R01.03)amendment effective 7/1/18.

- Update Appendix B-5 per CMS recommendations in the Community Choices Waiver(LA.0866.R01.03)amendment effective 7/1/18.

In compliance with CMS requirements, the department is posting the Adult Day Health Care Waiver amendment (LA.004.07.01) for public comment July 25, 2018 through August 24, 2018. CMS regulations require the Louisiana Department of Health to actively engage the public and give program participants, advocates, providers and other community stakeholders the opportunity to provide input regarding changes made to current waiver applications prior to the submission of final versions to CMS.
The Adult Day Health Care Waiver amendment is posted to the Office of Aging and Adult Services' website and may be accessed at the following address:
http://ldh.la.gov/index.cfm/newsroom/detail/4595. A hard copy of the amendment may be requested by calling the OAAS Help Line at 1-866-758-5035, and is available for viewing at the Office of Aging and Adult Services Regional Offices. The OAAS Regional Offices in your region can be found at:
http://www.dhh.louisiana.gov/index.cfm/directory/category/141 or by calling the OAAS Help Line at 1-866-758-5035. Interested persons may submit written comments to the Office of Aging and Adult Services, P.O. Box 2031 (Bin #14), Baton Rouge, LA 70821-2031 or by email to Melanie.Richard@la.gov. The deadline for receipt of all written comments is August 24, 2018 by 4:30 p.m."

2. The entire ADHC Waiver amendment and instructions for submitting comments (both hard copy and electronically) were posted for public comment from July 25, 2018 through August 24, 2018 on the Office of Aging and Adult Services website at web address: http://ldh.la.gov/index.cfm/newsroom/detail/4595

The State did not receive any comments from the public during the public comment period.

The tribal notice for this ADHC Waiver amendment was sent to the tribes on July 25, 2018. The state did not receive comments from the tribal contacts during the public comment period.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Bennett

First Name: Brian

Title: Section Chief

Agency: Bureau of Health Services Financing

Address: P.O. Box 91030

Address 2: 628 North Fourth Street - 6th Floor

City: Baton Rouge

State: **Louisiana**

Zip: 70821-9030

Phone: (225) 342-9846 **Ext:** ☐ **TTY**

Fax: (225) 342-9508

E-mail: Brian.Bennett@LA.GOV

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

LeBlanc

First Name: Tara

Title: Assistant Secretary

Agency: Office of Aging and Adult Services

Address: P.O. Box 2031

Address 2: 628 North Fourth Street, - 2nd Floor

City: Baton Rouge

State: **Louisiana**

Zip: 70821-2031

Phone: (225) 219-0223 **Ext:** ☐ **TTY**

Fax: (225) 219-0201

E-mail: Tara.LeBlanc@La.Gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Brian Bennett

State Medicaid Director or Designee

Submission Date: Nov 13, 2018

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Bennett

First Name: Brian

Title: Medicaid Section Chief

Agency: Bureau of Health Services Financing

Address: 628 North Fourth Street

Address 2: P. O. Box 91030

City: Baton Rouge

State: **Louisiana**

Zip: 70821-9030

Phone: (225) 342-9846 **Ext:** ☐ **TTY**

Fax: (225) 342-9168

E-mail: Brian.Bennett@La.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☒ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

For new applicants, the Behavior Pathway is being eliminated as one of the “pathways of eligibility” for the Nursing Facility Level of Care (NFLOC) criteria. However, this change will not impact those waiver participants that previously met, and continue to meet, NFLOC on the Behavior Pathway only. These waiver participants will continue to remain eligible for waiver services until the individual is discharged from long term care services or the individual has been found eligible for services in another Medicaid program or setting more appropriate to meet his/her needs.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may

reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The Office of Aging and Adult Services (OAAS) HCBS Settings Rule Transition Plan was included as part of the Louisiana Statewide Transition Plan submitted to CMS October 2016. The plan is currently under review with CMS. The plan may be accessed through the OAAS website using the following address: http://new.dhh.louisiana.gov/index.cfm/page/2030

OAAS conducted an analysis of its service settings for the Adult Day Health Care Waiver. Settings were categorized into the following groups:

1. Settings Presumed to be Fully Compliant with HCBS Characteristics;
- Participant owns housing or leases housing which is not provider-owned or operated
- Participant resides in housing which is owned or leased by a family member

2. Settings May Be Compliant, or With Changes Will Comply with HCBS Characteristics;
- Adult Day Health Care (ADHC)centers

3. Settings Are Presumed Non-HCBS But Evidence May Be Presented to CMS for Heightened Scrutiny Review;
- Adult Day Health Care centers located in a publicly or privately-owned inpatient facility

4. Settings Do Not Comply with HCBS Characteristics.
- N/A

Based on this analysis, Adult Day Health Care centers were the only service setting identified which warranted further assessment and scrutiny review to determine compliance with HCBS Settings requirements. As described in our transition plan, OAAS employed a multifaceted approach to assess and validate each ADHC setting. Each step is described in further detail below.

1. Public and Stakeholder Engagement
At the direction of the DHH, an interagency group was created to develop and manage the Statewide HCBS Settings Transition Plan. This team is responsible for ensuring the State's compliance with the new Settings Rule by evaluating current settings and developing a plan to demonstrate how Louisiana will comply and continue complying with the Settings Rule. Staff from OAAS, the Office of Behavioral Health (OBH), and the Office for Citizens with Developmental Disabilities (OCDD) began meeting on September 22, 2014. The group has continued monthly meetings to oversee the development of the Statewide Plan and to work in concert with each other and other associated State Agencies to complete the plan.

To meet the Transition Plan requirements, Louisiana published the public notice in the eight major daily newspapers of the State with the largest circulation. Notices were published in the following cities: Lafayette, Baton Rouge, New Orleans, Alexandria, Shreveport, Monroe, Lake Charles, and Houma. The public notice ran in the hard copies of the Legal Ad Section and published electronically on the Louisiana Press Association website. The public notice included detailed information on how to access a hard copy of the STP and how to submit comments (both electronic and written).

2. Systemic Assessment (Appendix B)
From October 1, 2014 to September 1, 2016, the three Program Offices conducted an internal, detailed examination of state statues, rules, regulations, policies, protocols, practices and provider manuals. These in-depth reviews compared state systems, residential settings, and non-residential settings to current practices to the requirements set forth with the CMS regulation. Current service definitions and provider qualifications across Louisiana's HCBS system were reviewed also to determine level of compliance with the HCBS regulation.

OAAS' systemic assessment identified changes were needed in the following in order to fully comply with the Settings Rule: Louisiana Administrative Code, ADHC Provider Manual, and the OAAS HCBS Participant Rights and Responsibilities document. OAAS has already made changes to its provider manual and will have the remaining changes finished by 12/1/17.

3. Site Specific Assessment - Provider Self-Assessment
The site specific assessment component was completed using a provider self-assessment tool (http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/HCBS/ADHC-Provider-Self-Assessment-Questions.pdf). The tool was drafted using CMS' guidance for non-residential settings and incorporated stakeholder comment that was received after it was circulated and posted for review. Self-assessments were made available online following a training with providers where OAAS provided an overview of the HCBS Settings Rule and instructions for completing the assessment. ADHC providers completed self-assessments in two phases (May-June 2015 and April 2016) with all providers submitting completed surveys by May 2016. A summary analysis of the self-assessment process and results was posted to the OAAS website and circulated for public review in May 2016.

OAAS required each provider to assemble a work group to both assess the ADHC setting and complete the survey. Members included provider staff, participants and family members, other providers (e.g. support coordinators), advocates, and other community stakeholders.

4. Site Specific Assessment - Validation
Following completion of the site specific assessment (self-assessments), OAAS staff conducted site visits on all ADHC centers (100%, 33 ADHC centers) as its primary method to validate the self-assessment data submitted by providers (see Appendix B.4; link: http://dhh.louisiana.gov/index.cfm/page/2030). OAAS regional office staff conducted site visits for each ADHC setting to both verify the accuracy of the self-assessment data and to provide technical assistance with completing any necessary remediation. Prior to scheduling the site visits, OAAS State Office staff provided training materials and interpretive guidelines for the site visit tool which focused on the requirements of the Rule and assessing these requirements from the participant's experience or point of view.

As an additional means of validation, OAAS staff will interview a representative, statistically valid (95% CI) sample of all waiver participants (composite sample of ADHC and CCW) as part of its annual 1915(c) quality assurance monitoring. OAAS monitors will visit participants in their homes and interview them about their experience with their services as it pertains to the Settings Rule. Utilizing a person-centered interview approach, OAAS Regional Office staff will gather important information on choice of setting, service, and the degree or extent the participant is engaged in their community. OAAS will collect this information directly from participants annually to gauge ongoing compliance with the HCBS Settings Rule.

5. Site Specific Remediation
Remediation required from the provider self assessments were completed during the site visit process. OAAS Regional Office staff delivered corrective action plans, reviewed these with the provider, offered technical assistance and/or strategies the provider could employ to comply with the requirement, and verified satisfactory implementation.

Based on the results of the site visits, additional corrective action plans will be sent to each provider not fully complying with the requirements of the Settings Rule. OAAS staff will track these plans to ensure the provider's remediation successfully addresses the noncompliance.

If the corrective action is not received or is inadequate to address the compliance issue, the provider will be disenrolled and another appropriate setting for the participant will be located. The disenrollment process will consist of: 1) provider disenrollment as a Medicaid provider; 2) a Transition Plan for participants; and 3) an internal appeal mechanism for participants and providers. Individuals will be given timely notice and a choice of alternate providers.

6. Ongoing Monitoring and Quality Assurance
Monitoring for ongoing compliance will employ a variety of quality assurance and monitoring practices and will build on the current quality system. Louisiana will ensure compliance with the HCBS Settings Rule by March 2019 through the use of systemic Quality Assurance and Improvement strategies. Public input will provide feedback to guide Louisiana's remediation and quality steps. Examples of monitoring and quality assurance activities will include ongoing scrutiny of any new or amended rules, standards, etc.; administration of an annual participant survey to monitor participant experience as it relates to the Settings Rule; and training of support coordinators to focus on participant experience with his/her environment as it relates to the Rule as part of the person-centered care planning process.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Office of Aging and Adult Services (OAAS)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

BHSF and OAAS have a common and concurrent interest in providing Medicaid eligible individuals access to waivers and other identified services through qualified providers, while ensuring the integrity of the Medicaid program is maintained.

The Louisiana Department of Health and Hospitals (DHH) is the umbrella agency designated as the Single State Medicaid Agency. Within DHH, BHSF is responsible for the administration of the state Medicaid program and is the administering agency for the ADHC waiver. OAAS is also located with DHH and is the operating agency for the ADHC waiver. BHSF and OAAS have an Interagency Agreement (IA) defining the responsibilities of each. The IA is to be reviewed yearly and updated as necessary. Among other activities, this IA requires BHSF and OAAS to meet quarterly to evaluate the waiver program and initiate necessary changes to policy and/or reimbursement rates and to meet quarterly with the Division of Health Economics to review the financial accountability reports for the waiver program.

There are nine OAAS regional offices within the state of Louisiana which perform regional waiver operation functions for the OAAS waivers as delegated and described in the CMS approved waiver document. The OAAS waiver offices perform under the guidance and supervision of OAAS, the state waiver operating agency. The OAAS waiver offices must comply with all regional Quality Improvement Strategy activities as described in the approved waiver document. Both the state operating agency (OAAS) and each of the OAAS regional operating offices share responsibility to meet the federally mandated assurances and sub-assurances for: Level of Care; Service Plan; and Health and Welfare.

To ensure compliance with federal regulations governing waivers, BHSF created the Medicaid Program Support and Waivers Section (MPSW) which oversees the administration of the Medicaid Home and Community Based Services (HCBS) programs operated by OAAS and the Office for Citizens with Developmental Disabilities (OCDD). Oversight is completed under the direction of the Medicaid Program Support and Waivers Section Chief.

BHSF oversight of operating agency performance is facilitated through the following committees:
DHH Variance Committee – meets at least quarterly to review financial utilization and expenditure performance of all OAAS waivers. Members are composed of representatives from OAAS, BHSF Division of Health Economics, DHH Finance/Budget, MPSW, and other BHSF sections as needed.

Medicaid HCBS Oversight Committee - meets at least quarterly with the specific purpose to ensure required oversight of the OAAS operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Members include HCBS quality management staff from MPSW and OAAS and it is chaired by the MPSW Section Chief or designee. Standing agenda items for the HCBS Oversight Committee include:

--OAAS operating agency staff present their analysis of all performance measure findings, remediation activities and systemic improvements to MPSW as defined in the 1915(c) waiver quality strategy;

--MPSW Section Chief or designee monitors quarterly/annual activities to ensure data collection, analysis, and remediation is occurring according to the approved waiver document.

--Based on evidence presented, MPSW staff provides technical assistance, guidance and support to the operating agency staff;

--MPSW performs administrative oversight functions for OAAS HCBS programs.

Medicaid/Program Offices Quarterly Meeting – Convenes at least quarterly to perform executive level oversight of the performance of HCBS waivers, assure their effectiveness and efficiency, and discuss any other programmatic issues common to the program offices and Medicaid. Goals are to act upon issues and recommendations received from the Medicaid HCBS Oversight Committee and other HCBS workgroups. This meeting is a forum for executive level problem resolution, planning, and development of quality redesign strategies. Members include representatives from MPSW, the Medicaid Director or Deputy Director, the OAAS

Assistant Secretary, and other designated staff.

MPSW/OAAS/HCBS Data Contactor Meetings– MPSW facilitates monthly meetings with OAAS and the Medicaid data contractor to discuss waiver issues, problems, and situations which have arisen and do not comport with program policy. At these meetings solutions are formulated, corrective actions are agreed upon, follow-up implemented by meeting attendees as necessary in the form of internal policy or provider policy.
Ad Hoc Cross-Population HCBS Oversight Meetings - Additional meetings will be held jointly between MPSW, OAAS, and OCDD on an as needed basis for the following purposes:

--Collaborate on design and implementation of a robust system of cross- population continuous quality improvement;

--Present Quality Improvement Projects (QIP);

--Share ongoing communication of what works, doesn't work, and best practices.

--Work collaboratively to implement new cross-population directives or federal mandates.

Oversight specific to each Appendix A-7 function delegated to OAAS:

1. Participant waiver enrollment – BHSF maintains supervision by approving the process for entry of individuals into the waiver. Supervision of compliant entry processes occurs during the monthly MPSW/OAAS/HCBS Data Contactor Meetings.

2. Waiver enrollment managed against approved limits –The variance committee meets at least quarterly to manage waiver enrollment against approved limits. This committee is composed of representatives from OAAS, DHH's Division of Health Economics, and MPSW. This function is accomplished through the review of reports compiled by OAAS and the Division of Health Economics using data obtained through the Medicaid data contractor and the Medicaid Management Information Systems (MMIS). These reports include the number of participants receiving services, exiting the waiver, offered a waiver opportunity, waiver closure summary, acute care utilization, and waiver expenditures. Admissions summary and level of care intake are discussed in the Medicaid Data Contractor meeting.

3. Waiver expenditures managed against approved levels– MPSW is responsible for completing the annual CMS-372 report utilizing data, submitting it to OAAS for review, and submitting to the Medicaid Director for final approval prior to submission. The variance committee meets quarterly to manage waiver expenditures against approved limits. This committee is composed of representatives from OAAS, DHH's Division of Health Economics, and MPSW. This function is accomplished through the review of reports compiled from data received through the Medicaid data contractor and MMIS. Reports include the number of participants receiving services, exiting the waiver, offered a waiver opportunity, waiver closure summary, acute care utilization, and waiver expenditures. The variance committee reviews expenditure trends and forecasts and discusses any planned or anticipated changes that could impact program expenditures.

4. Level of care evaluation – OAAS is responsible for submitting aggregated reports on level of care assurances to BHSF on an established basis as described in the Appendix B Quality Improvement Strategy (QIS) of the waiver application. OAAS formally presents level of care performance measures findings/remediation actions to MPSW via the Medicaid HCBS Oversight Committee.

5. Review participant service plans- OAAS is responsible for submitting aggregated reports on service plan assurances to BHSF on an established basis as specified in Appendix D of the waiver application. OAAS formally presents service plan performance measures findings/remediation actions to MPSW via the Medicaid HCBS Oversight Committee.

6. Prior authorization of waiver services - To ensure that payments are accurate for the services rendered OAAS monitors and oversees through the prior authorization process and the approved plan of care (POC). BHSF oversees OAAS's exercise of prior authorization activities through reports issued by the Medicaid data contractor and through monthly MPSW/OAAS/HCBS Data Contactor Meetings. System changes related to claims

processing and prior authorization can only be facilitated by BHSF. OAAS formally presents service plan performance measure findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee as described in Appendix D: QIS sub-assurance c.

7. Utilization management – Reports are generated quarterly from the Medicaid data contractor which include: number of participants who received all types of services specified in their service plan and number of participants who received services in the amount, frequency, and duration specified in the service plan. OAAS reviews these reports for trends and patterns of under-utilization of services. OAAS formally presents service plan performance measure findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee as described in Appendix D: QIS sub-assurance d.

8. Establishment of a statewide rate methodology - BHSF determines all waiver payment amounts/rates in collaboration with OAAS, Division of Health Economics, and as necessary the BHSF Rate & Audit section. MPSW monitors adherence to the rate methodology as described in Appendix I QIS.

9. Rules, policies, procedures, and information development governing the waiver program - OAAS develops and implements written policies and procedures to operate the waiver and must obtain BHSF approval prior to any rulemaking, provider notices, waiver amendments/renewals, or policy changes.

10. Quality assurance and quality improvement activities - To ensure compliance with federal regulations governing waivers, BHSF created the Medicaid Program Support and Waivers (MPSW) Section to oversee the administration of all Louisiana Medicaid waiver programs. Monitoring is completed under the direction of the MPSW Section Chief. The MPSW Section, through performance measures listed in the Quality Improvement Strategy (QIS) and systems described in Appendix H, ensures that OAAS performs its assigned waiver operational functions including participant health and welfare assurances in accordance with this document. OAAS formally presents performance measures findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Medicaid Data/Prior Authorization Contractor -
The Medicaid data contractor compiles and aggregates data on plans of care, such as date the initial plan is submitted and approved, date the annual POC is approved, and date the POC is received. This Medicaid data contractor also compiles and aggregates data on support coordination, provider services, waiver slots (both occupied and vacant); compiles and aggregates information on time lines, offerings of waiver slots and linkages to support coordination agencies; compiles and aggregates data on the waiver certification process; provides prior authorization functions; maintains the Request for Services Registry(RFSR); issues freedom of choice forms to the participant/family members to select a Support Coordination Agency; collects data from providers and provides various notifications to providers upon direction of OAAS or BHSF; and is responsible for the Electronic Visit Verification (EVV) of Adult Day Health Care providers.

Long Term Care Access contractor - This contractor serves as the point of entry for individuals to request waiver services via a toll-free telephone call center. Individuals seeking waiver services contact the toll-free number in order to have their names placed on the Adult Day Health Care (ADHC) Waiver Request for Services Registry (RFSR). This contractor conducts a screening on individuals who wish for their names to be placed on the ADHC RFSR.

Support Coordination Agencies - Support coordination agencies enrolled in Medicaid performs operational functions for level of care evaluation and re-evaluation as described in Appendix B-6.f. and for review of participant service plans as described in D-1.d.

Provider Enrollment/ Provider Agreements Contractor - The DHH Program Integrity Provider Enrollment (PE) unit manages the PE activities of the fiscal intermediary contractor's PE unit. All enrollments are cleared against the Office of State Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the System of Award Management (SAM) List of Debarred Entitles and Individuals. BHSF receives monthly Program Integrity reports for aberrant billing practices and enrollment as well as ongoing reports from Health Standards regarding provider licensing and certification.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Louisiana Department of Health and Hospitals(DHH) Bureau of Health Services Financing (BHSF), with input from the operating agency, is responsible for assessing the performance of the data management contractor, long term care access contractor, and support coordination agencies.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Medicaid Data/Prior Authorization Contractor:

The Medicaid contract monitor for the Medicaid Data/Prior Authorization Contractor reviews monthly a report tracking volume and timelines for contract activities and deliverables in the previous month. This report includes support coordination linkages, period of time between linkage and service delivery, number of new and closed support coordination linkages, and other summary statistics. The previous months billing information is also included in the report so that report and invoice are linked together. In addition, the data contractor submits a breakdown of staff resources allocated to the contract. MPSW staff, including the contract monitor, meets monthly with contractor to review performance. The data contractor also submits data files quarterly which are reviewed and archived by the contract monitor. If there is substandard performance, MPSW will require a corrective action plan and will monitor implementation.

Long Term Care Access contractor:

OAAS conducts monitoring on this contractor by reviewing the aggregated data reports detailing their contracted duties and specific performance measures submitted at least monthly to OAAS and MPSW. Reports include administrative activities (staffing rates and staff training), monthly call volumes, screening data (number applying for various waivers and OAAS programs; screening outcomes); requestors submitted to RFSR maintained by data contractor; and updates on issues or improvements to information technology used to support contract functions. MPSW, OAAS, and the Long Term Care Access contractor meet at least once every month to review contract work, problems, and deliverables. Invoices are not approved until monthly status reports are reviewed, approved, and all discrepancies resolved. When corrective action is required, a corrective action plan (CAP) is requested by OAAS and follow up will be conducted to evaluate the effectiveness of the CAP. Monitoring includes observation of contractor calls and processes and results in training, policy clarification, and other technical assistance and remediation as indicated. OAAS will utilize a record review audit tool to examine a random sample to determine whether the eligibility screening process was conducted and applied appropriately.

Support Coordination Agencies:

Retrospective review of Medicaid enrolled support coordinators in their performance of level of care evaluation and service plan review will occur on an annual basis through a Support Coordination Monitoring (SCM) review process performed by OAAS regional waiver staff under the programmatic oversight of OAAS. The SCM process includes a representative sample record review with performance measures described in the Level of Care, Service Plan and Health & Welfare Quality Improvement Strategies. The results of this monitoring will be entered into a Support Coordination Monitoring Data base which will generate aggregate reports annually by waiver population and by support coordination agency. Additionally, data with one hundred percent representativeness is available from the Medicaid data contractor for measures of timeliness. The results of this data will be analyzed and utilized by regional OAAS staff on a monthly basis to request and monitor corrective action based on the SCM results and enter remediation and compliance- related activities into the SCM data base. The state-wide report of discovery, remediation and improvement activities for level of care and service plan review will also be analyzed and acted upon by the appropriate committees as described in appendix H-1.a.i.

Provider Enrollment/ Provider Agreements Contractor:

The DHH Program Integrity Provider Enrollment (PE) unit manages the PE activities of the fiscal intermediary contractor's PE unit. All enrollments are cleared against the Office of State Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the System of Award Management (SAM) List of Debarred Entitles and Individuals. BHSF receives monthly Program Integrity reports for aberrant billing practices and enrollment as well as ongoing reports from Health Standards regarding provider licensing and certification.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the

performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☒	☒
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☐	☒
Execution of Medicaid provider agreements	☒	☐	☒
Establishment of a statewide rate methodology	☒	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
A.a.i.1 Number and percentage of performance measure reports which were received on time and complete with operating agency analysis and remediation activities. Numerator = Number of performance measure reports which were received on time and complete with operating agency analysis and remediation activities; Denominator = Total number of performance measure reports due.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.i.2 Number and percentage of Quality Improvement Projects (QIPs) initiated and submitted to the MPSW Section within three months of findings below the 86% threshold. Numerator = Number of Quality Improvement Projects (QIPs) initiated and submitted to the MPSW Section within three months of findings below the 86% threshold; Denominator = Total number of QIPs initiated and submitted to MPSW.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MPSW Tracking System

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.i.3 Number and percentage of implemented QIPs that were effective as evidenced by meeting the 86% threshold upon the subsequent monitoring cycle. Numerator = Number of implemented QIPs that were effective as evidenced by meeting the 86% threshold upon the subsequent monitoring cycle; Denominator = Total number of implemented QIPs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MPSW Tracking System

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.i.4. Number and percentage of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with the HCBS Settings Rule. Numerator = Number of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with the HCBS Settings Rule; Denominator = Total number of setting assessments.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.i.5. Number and percentage of changes in waiver policies that were approved by BHSF and presented for public notice prior to implementation by the operating agency. Numerator = Number of changes in waiver policies that were approved by BHSF and presented for public notice prior to implementation by the operating agency; Denominator= Total number of changes in waiver policies.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MPSW Tracking System

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

A.a.i.6. Number and percent of waiver slots certified annually that are less than or equal to

the unduplicated number of participants listed in Appendix B-3-a. Numerator = Number and percent of waiver slots certified annually that are less than or equal to the unduplicated number of participants listed in Appendix B-3-a; Denominator = Total number of slots certified.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid data contractor data systems

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Medicaid Data Contractor	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Medicaid Data Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.i.7. Number and percentage of waiver offers that were appropriately made across all geographical areas to applicants on the Request for Services Registry (RFSR), according to policy and criteria set forth by the State. Numerator = Number of appropriately made offers to applicants on the RFSR; Denominator = Total number of waiver offers made.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid data contractor data system

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Medicaid data contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Medicaid Data Contractor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

A.a.i.1 – A.a.i.5
Aggregated data collected for Performance Measures A.a.i.1 – A.a.i.5 are reviewed and analyzed quarterly by via the Medicaid HCBS Oversight Committee. When remediation is indicated, the Committee discusses appropriate remediation activities to resolve identified compliance issues and address systemic improvements when indicated. To achieve this end, MPSW provides technical assistance, guidance, and support to the operating agency staff. Committee minutes document remediation actions and results of these actions are presented at subsequent meetings to verify effectiveness.

The Medicaid HCBS Oversight Committee meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the BHSF/Program Offices HCBS Executive Committee. Members of the Medicaid HCBS Oversight Committee include HCBS quality management staff from MPSW and OAAS and it is chaired by the MPSW Section Chief or designee.

A.a.i.6

MPSW and OAAS meet monthly with the Medicaid data contractor to discuss problems/issues identified and how to remediate. At these meetings, the members review the Daily Count of Offers, Linkages and Certifications report generated by the data contractor which includes: waiver slots available; pre-linkage, linkages to support coordinator; offers accepted; offers too recent for a response; vacancies to be offered; offers accepted and linked; recipients linked and certified; recipients linked and not certified. This report is reviewed and analyzed to determine whether the yearly maximum number of unduplicated participants offered a waiver opportunity is nearing the limit. If the yearly maximum number of unduplicated participants offered a waiver opportunity is approaching the limit, the state will submit a waiver amendment to CMS to modify the number of participants. Remediation of specific problems/issues/discrepancies identified are addressed in the monthly meetings and documented in the Medicaid data contractor meeting minutes (which are shared with OAAS) and the MPSW Tracking System.

A.a.i.7

MPSW and OAAS meet monthly with the Medicaid data contractor to discuss problems/issues identified and how to remediate. At these meetings, the members review the Count of Slot Types report generated by the data contractor which includes: initial allocated slots; reallocated slots due to closures; current number of allocated slots; current number of slots linked and number of remaining slots open. This report is reviewed and analyzed to identify the number of slots available for offers. OAAS and MPSW supervise whether offers are made appropriately according to established policy and criteria. If there are instances identified where offers were made inappropriately, MPSW meets with the data contractor and OAAS to address the situation and develop a plan for corrective action for resolution.
Remediation of specific problems/issues/discrepancies identified are addressed in the monthly meetings and documented in the Medicaid data contractor meeting minutes (which are shared with OAAS) and the MPSW Tracking System.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	22	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

For adults with physical disabilities (age 22 - 64) in the ADHC Waiver, Louisiana will continue to provide waiver services to these participants whose age exceeds the maximum age limit of 64.

The Behavior Pathway is being eliminated for initial applicants. Persons already receiving ADHC Waiver services that only meet Nursing Facility Level of Care (NFLOC) on the Behavior Pathway will continue to remain eligible for services until discharged from long term care services or found eligible for services in another Medicaid program or setting more appropriate to meet their needs.

Details on all pathways of eligibility can be found in Louisiana Administrative Code-LAC 50:II.10156 and are also included in Appendix B-6.d. as required per the CMS Technical Guide.

The seven (7) pathways of eligibility are as follows:

• Activities of Daily Living (ADL): The intent of the Activities of Daily Living (ADL) pathway is to determine the individual's self-care performance in Activities of Daily Living during a specified look-back period. Consideration is given to what the individual actually did for himself or herself and/or how much help was required by family members or others.

• Cognitive Performance: This pathway identifies individuals with the following cognitive difficulties:
o short term memory which determines the individual's functional capacity to remember recent events;
o cognitive skills for daily decision making which determines the individual's actual performance in making everyday decisions about tasks or Activities of Daily Living;
o making self-understood which determines the individual's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

• Physician Involvement: The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

• Treatments and Conditions Pathway: The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

• Skilled Rehabilitation Therapies: The intent of this pathway is to identify individuals who have received, or are scheduled to receive, physical therapy, occupational therapy, or speech therapy (as outlined in the LAC citation above).

• Behavior: The intent of this pathway is to identify individuals who have experienced repetitive behavioral challenges which have impacted their ability to function in the community during the specified look-back period. This pathway is being eliminated for new applicants. However, those individuals already receiving waiver services who, in the past, only met nursing facility level of care on the behavior pathway will continue to remain eligible for services until discharged from long term care services or found eligible for services in another Medicaid program or setting more appropriate to their needs.

• Service Dependency: The intent of this pathway is to identify individuals who are currently in a nursing facility or have been receiving services continuously since 12/01/06 or earlier, and ongoing services are required in order for the individual to maintain current functional status.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Once participants in the "disabled (physical)" target subgroup (age 22-64) reach the maximum age limit, they will continue to receive services under the "aged" target subgroup which has no maximum age limit.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	935
Year 2	935
Year 3	935
Year 4	935
Year 5	935

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*:

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	825
Year 2	825
Year 3	825
Year 4	825
Year 5	825

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

LDH is responsible for the ADHC Request for Services Registry (RFSR). Individuals who wish for their names to be placed on the ADHC RFSR shall contact the toll-free telephone number maintained by the long term care access contractor.

Adult Day Health Care (ADHC) Waiver opportunities shall be offered to individuals on the RFSR pursuant to priority groups. The following groups shall have priority for ADHC Waiver opportunities, in the order listed: (1) individuals with substantiated cases of abuse or neglect referred by Adult Protective Services (APS) who without ADHC Waiver services, would require institutional placement to prevent further abuse and neglect; (2) individuals who have been discharged after a hospitalization within the past thirty (30) days that involved a stay of at least one night; (3) individuals admitted to or residing in a nursing facility who have Medicaid as the sole payer source for the nursing facility stay, with the intent that they be discharged to the community; and (4) all other eligible individuals on the RFSR, by date of first request for services.

If an applicant is determined to be ineligible for any reason, the next individual on the RFSR is notified as stated above and the process shall continue until an individual is determined eligible. An ADHC Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- ☒ **A special income level equal to:**

Select one:

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: ☐

- ○ **A dollar amount which is lower than 300%.**

Specify dollar amount: ☐

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☐ **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

Specify percentage amount: ☐

- ☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Medically needy with spend down consisting of the state average monthly cost for private patients in nursing facilities as used for assessing a transfer of assets penalty and other incurred expenses to reduce an individual's income to or below the medically needy income standard.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals

in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

○ **Not Applicable (see instructions)**
○ **SSI standard**
○ **Optional state supplement standard**
◉ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**
○ **AFDC need standard**
◉ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the state plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:
  - ( ) **Other standard included under the state Plan**

    Specify:

- ( ) **The following dollar amount**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

◉ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

ii. Frequency of services. The state requires (select one):

◉ **The provision of waiver services at least monthly**

○ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○ **Directly by the Medicaid agency**

○ **By the operating agency specified in Appendix A**

◉ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

Support Coordination agencies enrolled with Medicaid and Certified by OAAS.

○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing the initial level of care evaluation must have the following qualifications:

- Bachelor's or Master's degree in social work from a program accredited by the Council on Social Work Education; or
- Bachelor's or Master's degree in nursing (RN) currently licensed in Louisiana (one year of paid experience will substitute for the degree);
  or
- Bachelor's or Master's degree in a human service related field which includes: psychology, education, counseling, social services, sociology,philosophy, family and participant sciences, criminal justice, rehab services, substance abuse, gerontology, and vocational rehabilitation;
  or
- Bachelor’s degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed above in the human service related field.

All individuals who make level of care evaluations must also be trained and certified by DHH.

There is no differentiation between who can and cannot conduct initial and subsequent evaluations.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Applicants and participants are evaluated/re-evaluated using the Minimum Data Set for Home Care (MDS-HC) assessment tool. The MDS-HC is designed to determine if a participant meets/continues to meet Level of Care (LOC) by assessing multiple key domains of function, health, social support and service use. The following seven (7) factors or "pathways of eligibility", (also specified in Louisiana Administrative Code-LAC 50:II.10156) are:

• Activities of Daily Living (ADL): The intent of the Activities of Daily Living (ADL) pathway is to determine the individual's self-care performance in Activities of Daily Living during a specified look-back period. Consideration is given to what the individual actually did for himself or herself and/or how much help was required by family members or others.

• Cognitive Performance: This pathway identifies individuals with the following cognitive difficulties:
o short term memory which determines the individual's functional capacity to remember recent events;
o cognitive skills for daily decision making which determines the individual's actual performance in making everyday decisions about tasks or Activities of Daily Living;
o making self understood which determines the individual's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

• Physician Involvement: The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

• Treatments and Conditions Pathway: The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

• Skilled Rehabilitation Therapies: The intent of this pathway is to identify individuals who have received, or are scheduled to receive, physical therapy, occupational therapy, or speech therapy (as outlined in the LAC citation above).

• Behavior: The intent of this pathway is to identify individuals who have experienced repetitive behavioral challenges which have impacted his/her ability to function in the community during the specified look-back period. This pathway is being eliminated.
However, those individuals already receiving waiver services who, in the past, only met nursing facility level of care on the behavior pathway
will continue to remain eligible for services until the individual is discharged from long term care services or the individual has been found
eligible for services in another program or setting more appropriate to their needs.

• Service Dependency: The intent of this pathway is to identify individuals who are currently in a nursing facility or have been receiving services continuously since 12/01/06 or earlier, and ongoing services are required in order for the individual to maintain current functional status.

Following completion of the MDS-HC conducted by an OAAS certified assessor, the results are entered into a software system named Telesys which uses algorithms to identify factors which would qualify an individual as having met Level of Care on any of the pathways listed above. A review of the final results is also conducted by the OAAS certified assessor and that assessor's supervisor to ensure accuracy of the final determination.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

Different instruments are used to determine level of care for the waiver and level of care for institutional services, however both instruments use the same criteria and a common sub-set of questions to determine if level of care is met. Both tools are derived from the MDS suite of tools developed by the InterRAI group.

Louisiana worked with InterRAI members from the University of Michigan to develop a level of care tool called the LOCET that is used to determine if applicants meet level of care for institutional care. LOCET is derived from the Minimum Data Set 3.0 (for Nursing Homes)- MDS 3.0 and uses a subset of questions and algorithms from that comprehensive assessment instrument to determine that level of care is met.

For waiver services, the instrument used to determine level of care is the Minimum Data Set for Home Care (MDS-HC), a sister-tool to the MDS 3.0 which includes not only the nursing facility level of care questions, but is also designed to gather comprehensive assessment information needed to develop care plans for waiver participants. For these reasons the MDS-HC is used as the tool for determining nursing facility level of care for home and community-based applicants. The criteria which trigger nursing facility level of care are the same as on the LOCET. (These criteria are noted in item B-6-d).

The Minimum Data Set for Home Care (MDS-HC) is used for collection of assessment information relative to waiver initial evaluation (level of care determination of eligibility). The MDS-HC is designed for use by non-clinicians. It was developed by the interRAI group after years of study of populations similar to those in the Louisiana waiver programs. No medical background is needed for an assessor to be qualified to conduct an MDS-HC assessment. OAAS requires that the support coordinator who conducts the MDS-HC assessment be trained and certified by OAAS before conducting these assessments.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Once the individual receives a waiver offer and is linked to the support coordination agency that he/she selected, the support coordinator completes the MDS-HC during a face-to-face assessment visit which is usually conducted in the individual's home but which may be conducted in another location of the applicant's choosing. The support coordinator must complete the face-to-face assessment within seven (7) calendar days following the linkage. Information collected via the MDS-HC assessment is entered into a computer program which uses programmed algorithms, described in B-6-d, to determine if an applicant has met level of care. If level of care is met, the support coordinator proceeds in developing a plan of care (POC) based on the totality of the MDS-HC assessment. If level of care is not met, the OAAS Regional Office reviews the MDS-HC and level of care results to make a final level of care determination. Regional Office review may also include a home visit to the applicant and completion of a new MDS-HC.

Reevaluations:

The process for level of care reevaluation is the same as for initial level of care evaluation. (Refer to section B.6.i. for the annual reevaluation timelines.)

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

  Specify the other schedule:

Reevaluation of level of care is conducted no less than every twelve (12) months or when there is a change in the individual's status that requires a re-assessment.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

○ **The qualifications are different.**
Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Timeliness of level of care reevaluations is monitored and ensured via the Case Management Information System (CMIS) provided by the Medicaid data contractor.

The data contractor releases Prior Authorizations (PAs) for support coordination only if all required tasks (monthly, quarterly, and annual) are completed and entered into CMIS in a timely manner.

Support Coordination Agency (SCAs) supervisors have access to an electronic tickler generated from the CMIS database indicating when POCs are going to expire. OAAS Regional Offices (RO) access a comparable report provided by the data management contractor. This allows all parties to monitor timeliness of reevaluation.

Documentation of LOC reevaluation which is included in the approved Plan of Care (POC) packet must be submitted by the SC Supervisor to the data contractor and/or RO within 14-90 days prior to the expiration date.

The SC Supervisor submits documentation of the SC Supervisor LOC/POC approval to the data contractor. The contractor enters the SC Supervisor LOC/POC submittal date into the prior authorization database.

If the submittal of the SC Supervisory LOC/POC approval is less than 14 days from the expiration date, the PA for SC services is not released for a minimum of one month.

If review of reports from the data contractor indicate ongoing failure to perform reevaluations within required timeframes, the RO will follow up with the SCA agency for purposes of remediation as described in Appendix B Quality Improvement b. Methods for Remediation/Fixing Individual Problems.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Level of care records are available on an assessment and level of care database maintained by OAAS and the SMA has access to these records at all times. Records of evaluations and reevaluations are maintained for a minimum of 6 years.

Comprehensive assessment information is made available to all members of the planning team where it is deemed necessary.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.a.i.a.1. Number and percent of new enrollees who had a level of care indicating need for institutional level of care prior to receipt of services. Percentage= Number of new enrollees who had a level of care indicating need for institutional level of care prior to receipt of services / Total number of new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Data Contractor data system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Medicaid data contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.a.i.c.1. Number and percent of participants whose initial and annual LOC determinations forms/instruments were completed as required by the state. Numerator = Number of participants whose initial and annual LOC determinations forms/instruments that were completed as required by the state; Denominator = Total number of participants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
B.a.i.c.2 Number and percent of participants whose LOC determinations were made by a qualified evaluator. Numerator = Number of participants whose LOC determinations were made by a qualified evaluator; Denominator = Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample**

		Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Regarding B.a.i.c.1 and B.a.i.c.2, OAAS regional office staff conduct monitoring of support coordination agencies at least annually utilizing the OAAS Support Coordination Monitoring Tools: Participant Interview, Participant Record Review, Support Coordinator Interview, and Agency Review. The sample size will be large enough for a confidence level of 95% and will be generated on the first day of each waiver year. The number of participants from the statewide sample to be included in each support coordination agency (SCA) sample will be proportional to the percentage of participants linked to each agency on the first day of each waiver year. A SCA's sample size will be determined separately for each region in which the SCA operates.

Regarding B.a.i.c.2, OAAS reviewers will identify through record review the support coordinator who performed the LOC evaluation. The OAAS reviewer will then check the MDS-HC Training Database to determine if the LOC evaluator received MDS-HC certification from OAAS.

Discrepancies or inaccuracies detected during the record review are corrected upon discovery.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The State's method for addressing individual problems identified through performance measure B.a.i.a.1 is as follows:

OAAS Regional Office receives quarterly reports from the Medicaid Data Contractor for review. If LOC discrepancies are identified, the regional office will contact the support coordination agency. The support coordination agency will have 10 days to correct the discrepancies. Depending upon the frequency and persistence of such problems, OAAS may pursue sanctions as outlined in the Support Coordination Performance Agreement. The remediation activities will be documented in a spreadsheet by the regional office.

The State's method for addressing individual problems identified through performance measures B.a.i.c.1 and B.a.i.c.2. are as follows:

Regional Office staff perform monitoring of Support Coordinator Agencies (SCA) at least annually utilizing the OAAS Support Coordination Monitoring Tools: Participant Interview; Participant Record Review; Support Coordinator Interview; and Agency Review. The processes for scoring and determining the necessity for corrective actions are located in the Support Coordination Agency Monitoring Policy and Procedures Manual. After all elements are assessed and scored, the Regional Office reviewer documents the findings, including the Statement of Determination which delineates every remediation required within the LOC/POC and required responses/corrective action plans required from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. The Regional Office and/or State Office follow-up according to timelines associated with each level to ensure that corrective action plans are implemented and effective. If a corrective action plan, progress report and/or follow-up report remain unapproved by the time of the next annual review the agency placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Louisiana Department of Health and Hospitals(DHH) Long-Term Care Access contractor gives individuals and/or their responsible representative the choice of either institutional or home and community-based services and verbally informs them of their alternatives at the time an individual first requests long term care services. Individuals are given the option to choose between institutional or home and community-based services in writing and are informed of their alternatives under the waiver at the time they are going through the Medicaid application and determination process. These options are also sent by the Medicaid data contractor at the time the waiver offer is made and the choice is explained by the support coordinator. The Long Term Care Program Choice Decision form, Support Coordination Choice/Release of Information form and Adult Day Health Care (ADHC) Provider Choice/Release of Information form are all used to document freedom of choice.

When the initial waiver offer is made, the data contractor mails the offer with the Support Coordination Agency (SCA)selection form. If the contractor does not receive the form with a selection of a SCA within two (2)weeks, the form is re-sent. If in another two (2) weeks a selection of a SCA has not been made by the waiver participant, the contractor auto-selects a SCA. The auto-selection process is designed to ensure participants are equally assigned among all available SCAs. It is at the participant's discretion to select another SCA if they are not satisfied with the choice. The waiver participant will attest that FOC of all service providers was given by his/her signature on the Plan of Care (POC).

At initial and upon annual recertification of the participant, the support coordinator discusses the availability of all services in the waiver and the direct service provider freedom of choice form. The direct service provider freedom of choice lists names of local providers enrolled in Medicaid and this listing is available on the OAAS website. The list of providers on the website is current and is maintained by OAAS.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Forms are maintained by OAAS regional offices, the data contractor and/or the support coordination agencies.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

A language service vendor is under contract with DHH. Additionally, support coordination agencies must utilize a language service vendor, if needed for a Limited English Proficient (LEP) waiver participant.

All BHSF application forms are published in English, Spanish, and Vietnamese and are available in alternative format upon request.

Alternative methods of communication are used as the situation arises. Language services for LEP are provided in two (2) main ways: oral and written language services (interpretation and translation, respectively). Both offer substantial flexibility in determining the appropriate mix and medium.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Adult Day Health Care**		
Statutory Service	**Support Coordination**		
Other Service	**Transition Intensive Support Coordination**		

Service Type	Service		
Other Service	Transition Service		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services furnished as specified in the plan of care at an ADHC center, in a non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the participant. All ADHCs shall be compliant with the HCBS Settings Rule and will incorporate appropriate non-residential qualities of a home and community-based setting as described in 42 CFR §441.301(c)(4)(5).

Adult Day Health Care (ADHC) Services include:

- One nutritionally-balanced hot meal and a minimum of two snacks served each day;
- Transportation between the participant's place of residence and the ADHC center, in accordance with licensing standards;
- Assistance with activities of daily living;
- Health and nutrition counseling;
- Individualized daily exercise program;
- Individualized goal-directed recreation program;
- Daily health education;
- Medical care management;
- Transportation to and from medical and social activities if the participant is accompanied by the ADHC center staff; and
- Individualized health/nursing services.

Nurses are involved in the participant’s service delivery, as specified in the plan of care or as needed. Each participant has a plan of care from which the ADHC provider develops an individualized service plan. If the individualized service plan calls for certain health and nursing services, the nurse on staff ensures that said services are delivered while the participant is at the ADHC center.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services are furnished on a regularly scheduled basis, not to exceed 10 hours a day and no more than 50 hours a week.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health Care

Provider Category:

Agency

Provider Type:

Adult Day Health Care

Provider Qualifications

License *(specify):*

Agency must be licensed according to the Louisiana Revised Statutes (R.S 40:2120.41 through 2120.47)

Certificate *(specify):*

Other Standard *(specify):*

Agency must be enrolled as an ADHC Medicaid provider.

Qualifications for ADHC center staff are set forth in the Louisiana Administrative Code (LAC).

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and annual

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Support Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Support Coordination services assist participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services.

Support Coordination Agencies shall be required to perform the following core elements of support coordination:

*Intake;
*Assessment/Re-assessment;
*Plan of care development and revision;
*Linkage to direct services and other resources;
*Coordination of multiple services among multiple providers;
*Monitoring(regular, at least monthly)/follow-up;
*Evaluation and re-evaluation of level of care and need for waiver services;
*Ongoing assessment and mitigation of health, behavioral and personal safety risk;
*Responding to participant crises;
*Critical incident management; and
*Transition/discharge and closure.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Support Coordination

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:
Agency

Provider Type:

Support Coordination

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified as a case management (support coordination) agency by DHH/OAAS.

Other Standard *(specify):*

Must enroll as a Medicaid support coordination agency provider.

Must sign and comply with the OAAS performance agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

OAAS

Frequency of Verification:

Initial and annual

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transition Intensive Support Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Services that will assist participants who are currently residing in nursing facilities in gaining access to needed waiver and other State plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services. Support coordinators shall initiate and oversee the process for assessment and re-assessment, as well as be responsible for ongoing monitoring of the provision of services included in the participant's approved Plan of Care (POC). This service is paid up to 6 months (no more than 180 calendar days) prior to transition from the nursing facility when adequate pre-transition supports and activity are provided and documented.

The scope of Transition Intensive Support Coordination does not overlap with the scope of Support Coordination.

This service is available to participants during transition from a nursing facility to the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Support coordinators may assist individuals with their transitioning up to 6 months (no more than 180 calendar days) while the individual is still residing in the nursing facility.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Support Coordination

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition Intensive Support Coordination

Provider Category:

Agency

Provider Type:

Support Coordination

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified as a case management (support coordination) agency by DHH/OAAS.

Other Standard *(specify):*

Must enroll as a Medicaid support coordination agency provider.

Must sign and comply with the OAAS performance agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

OAAS

Frequency of Verification:

Initial and annual

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transition Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transition Services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for an ADHC Waiver opportunity and are transitioning from a nursing facility to a living arrangement in a private residence where the individual is directly responsible for his/her own living expenses. Allowable expenses are those necessary to enable the individual to establish a basic household that does not constitute room and board, but includes: security deposits that are required to obtain a lease on an apartment or house; specific set-up fees or deposits (e.g. telephone, electric, gas, water and other such necessary housing set up fees or deposits); essential furnishings to establish basic living arrangements; and health and welfare assurances (e.g. pest control/eradication, fire extinguisher, smoke detector and first aid supplies/kit). These services must be prior approved in the participant's plan of care. These services do not include monthly rental, mortgage expenses, food, monthly utility charges and household appliances and/or items intended for purely recreational purposes. These services may not be used to pay for furnishing or set-up living arrangements that are owned or leased by a waiver provider. Support coordinators shall exhaust all other resources to obtain these items prior to utilizing the waiver.

This service is available to participants during transition from a nursing facility to the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

$1,500 lifetime maximum per participant. When the participant requires services that exceed the lifetime maximum allowed, OAAS staff and/or the support coordinator shall identify and refer the participant and/or responsible representative to additional resources through the Aging and Disabled Resource Center (ADRC), Council on Aging, Governor's Office of Elderly Affairs (GOEA), informal supports, etc.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Support Coordination Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition Service

Provider Category:

Agency

Provider Type:

Support Coordination Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified as a case management (support coordination) agency by DHH/OAAS.

Other Standard *(specify):*

Must enroll as a Medicaid support coordination provider

Must sign and comply with the OAAS performance agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Aging and Adult Services (OAAS)

Frequency of Verification:

Initial and annual

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The Louisiana State Police (LSP), or the LSP designee, perform the actual criminal history/background checks and security check on individuals who provide waiver services.

A sample of employee background checks/security checks are reviewed by Health Standards Section (HSS) during licensing reviews. HSS is the regulatory agency for DHH. HSS licenses Adult Day Health Care (ADHC) providers and ensures compliance with the applicable rules and regulations. State law mandates that ADHCs conduct criminal history back ground checks and sex offender checks on all non-licensed personnel at the time an offer of employment is made. HSS surveyors will assess the provider's compliance with the requirement at the time surveys are conducted.

The Louisiana State Police (LSP), or the LSP designee companies they recognize as competent, perform the actual criminal history/background checks and security check on the individual.

OAAS also follows the policy in the LA Revised Statutes for the persons working with the elderly and adults who are disabled:
-LA R.S. 15:1501-1511 Abuse and Neglect of Adults; and
-LA R.S. 40:1203.2 -1203.3 Criminal History Checks on Non-Licensed Persons and Licensed Ambulance Personnel

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

DHH maintains a Direct Service Worker (DSW) registry to include information concerning any documentation of any investigation for findings of abuse, neglect, extortion, exploitation and misappropriation of property, including a summary of findings after an action is final. If a person's name appears on the registry, they are prohibited from employment.

The DSW registry contains the names of workers on a statewide basis that have substantiated findings of abuse, neglect, exploitation or misappropriation of property. These findings would be placed after the individual has been formally notified by certified letter that the allegation/s have been brought against them and they have been afforded their right to an informal reconsideration and/or administrative appeal. If the individual is a certified nursing assistant, the Louisiana Nurse Aide registry contains the names of all nurse aides with current certification as well as those who have a finding placed for abuse, neglect, exploitation or misappropriation of property. This is also recorded on a statewide basis. In addition to the DSW registry check or Nurse Aide Registry check, criminal history checks are done in accordance with LA RS 40:1203 (1-5)

- The criminal background check is a statewide check.
- Additionally a security check is required which is a search of the national sex offender registry.

Providers are required to verify upon hire and every 6 months that none of their direct care staff have been placed on this DSW registry that is maintained by HSS. HSS surveyors will review a sample of employee files to assess the provider's' compliance with the requirement at the time surveys are conducted.

Program Integrity maintains the Adverse Action website that contains individuals and providers who are excluded by LDH (State Exclusions). The Office of Inspector General maintains the List of Excluded Individuals & Entities (LEIE) database that contains national exclusions. These two databases are to be checked upon hire and monthly thereafter.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure

that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives who provide waiver services to the participant must meet the same standards as non-relatives and become an employee of the participant's provider. A spouse or legally responsible relative shall not be employed by the provider to provide any waiver service to the participant.

To ensure that payments are accurate for the services rendered, OAAS monitors and oversees the requirements of the provider through the prior authorization process and the approved plan of care (POC).

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

ADHC providers:

1. Obtain Facility Need Review (FNR) approval from DHH.
2. Complete all HSS licensing requirements as outlined in the ADHC initial licensure packet found at http://new.dhh.louisiana.gov/index.cfm/page/525
3. Complete Medicaid enrollment through DHH's fiscal intermediary by completing the basic enrollment packet in addition to the ADHC provider type packet. These enrollment packets may be found at http://www.lamedicaid.com/provweb1/Provider_Enrollment/newenrollments.htm

Support Coordination:

1. Obtain certification approval from OAAS. Certification approval includes an on-site visit from OAAS staff to confirm compliance with all requirements set forth in the certification standards.
2. Sign the OAAS SC Performance Agreement.
3. Complete Medicaid enrollment through DHH's fiscal intermediary by completing the basic enrollment packet in addition to the OAAS Case Management (Support Coordination) provider type packet. These enrollment packets may be found at http://www.lamedicaid.com/provweb1/Provider_Enrollment/newenrollments.htm

Following completion of the above steps, the provider is listed on the Provider Freedom of Choice form for the appropriate service areas for which they have completed the enrollment and licensure/certification processes.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.a.i.a.1. Number and percentage of new ADHC providers who meet ADHC licensing standards prior to furnishing waiver services. Percentage = Number of ADHC providers who meet ADHC licensing standards prior to furnishing waiver services. / Total number of initial ADHC providers***

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASPEN

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.a.i.a.2. Number and percentage of ADHC providers that continually meet ADHC licensing standards. Percentage = Number of ADHC providers that continually meet ADHC licensing standards / Total number of licensed ADHC providers*****

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASPEN

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.a.i.a.3. Number and percentage of ADHC providers who conducted background checks on direct services workers in accordance with state laws/policies. Numerator = Number of ADHC providers who conducted background checks on direct services workers in accordance with state laws/policies; Denominator = Total number of ADHC providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASPEN

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.a.i.c.1. The number and percentage of ADHC licensed providers meeting annual provider training requirements in accordance with state laws/polices. Numerator = Number of ADHC licensed providers meeting annual provider training requirements in accordance with state laws/polices; Denominator= Total number of licensed ADHC providers.****

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

C.a.i.a.1.and C.a.i.a.2

- For every deficiency cited, the provider shall submit a plan of correction. If acceptable, a follow-up survey will be conducted. The follow-up survey will be conducted either by on-site visit or via written evidence submitted by the provider, depending on the deficiency citations. The plan of correction will require the provider to give a completion date (no more than 60 days) for each deficiency as well as the staff person responsible for monitoring and assuring continued compliance. Failure of the ADHC to achieve substantial compliance may result in a provisional license, non-renewal, license revocation and cancellation of the Medicaid provider agreement. Civil monetary penalties may be imposed for deficiencies resulting in abuse, neglect, actual harm or death or when there are repeat deficiencies within an 18 month period. Failure to pay civil monetary penalties will result in withholding money from vendor payment.
- If a provisional license is issued, an on-site follow-up survey will be conducted at the ADHC prior to the expiration of the provisional license. A provisional license may be issued for a maximum period of six months. If the on-site follow-up survey determines that the ADHC has not corrected the deficient practices, the department may choose to not offer license renewal or a license revocation process may be initiated.

C.a.i.a.3.

- When conducting licensing surveys, Health Standards Section will monitor a 10% sample of Direct Service Worker (DSW) personnel files to ensure background checks are completed in accordance with state laws/polices.
- Further, DHH is required to maintain a DSW registry to include information concerning any documentation of any investigation for findings of abuse, neglect, extortion, exploitation and misappropriation of property, including a summary of findings after an action is final. The ADHC is required to check the DSW registry upon hire and every 6 months to determine if a prospective hire is registered. When conducting licensing surveys, Health Standards Section will monitor a 10% sample of Direct Service Worker (DSW) personnel files to ensure a DSW registry check is done upon hire and every 6 months.
- For non-compliance, deficiencies shall be cited and the provider shall submit a plan of correction. If acceptable, a follow-up survey will be conducted. The follow-up survey will be conducted either by onsite visit or via written evidence submitted by the provider, depending on the deficiency citations. The plan of correction will require the provider to give a completion date (no more than 60 days) for each deficiency as well as the staff person responsible for monitoring and assuring continued compliance. Failure of the ADHC to achieve substantial compliance may result in a provisional license, non-renewal, license revocation and cancellation of the Medicaid provider agreement. Civil monetary penalties may be imposed for deficiencies resulting in abuse, neglect, actual harm or death or when there are repeat deficiencies within an 18 month period. Failure to pay civil monetary penalties will result in withholding money from vendor payment.
- If a provisional license is issued, an on-site follow-up survey will be conducted at the ADHC prior to the expiration of the provisional license. A provisional license may be issued for a maximum period of six months. If the on-site follow-up survey determines that the ADHC has not corrected the deficient practices, the department may choose to not offer license renewal or a license revocation process may be initiated.

C.a.i.c.1.

- When conducting licensing surveys, Health Standards Section will monitor a 10% sample of personnel files to ensure required initial and annual training are completed in accordance with state regulations.
- For non-compliance, deficiencies shall be cited and the provider shall submit a plan of correction. If acceptable, a follow-up survey will be conducted. The follow-up survey will be conducted either by onsite visit or via written evidence submitted by the provider, depending on the deficiency citations. The plan of correction will require the provider to give a completion date (no more than 60 days) for each deficiency as well as the staff person responsible for monitoring and assuring continued compliance. Failure of the ADHC to achieve substantial compliance may result in a provisional license, non-renewal, license revocation and cancellation of the Medicaid provider agreement. Civil monetary penalties may be imposed for deficiencies resulting in abuse, neglect, actual harm or death or when there are repeat deficiencies within an 18 month period. Failure to pay civil monetary penalties will result in withholding money from vendor payment.
- If a provisional license is issued, an on-site follow-up survey will be conducted at the ADHC prior to the expiration of the provisional license. A provisional license may be issued for a maximum period of six months. If the on-site follow-up survey determines that the ADHC has not corrected the deficient practices, the department may choose to not offer license renewal or a license revocation process may be initiated.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the

amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The settings are not fully compliant at this time. Please refer to Attachment #2.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Care (POC)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

• Bachelor's or Master's degree in social work from a program accredited by the Council on Social Work Education; or
• Bachelor's or Master's degree in nursing (RN) currently licensed in Louisiana (one year of paid experience will substitute for the degree); or
• Bachelor's or Master's degree in a human service related field which includes: psychology, education, counseling, social services, sociology, philosophy, family and participant sciences, criminal justice, rehab services, substance abuse, gerontology, and vocational rehabilitation; or
• Bachelor’s degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed above in the human service related field.

Additionally, case managers/support coordinators must meet all qualifications as specified in Appendix C-1/C-3.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Prior to the initial visit by the Support Coordination Agency (SCA), the participant is sent a fact sheet describing the services available under the Adult Day Health Care (ADHC) Waiver. During the initial visit, which is prior to the Plan of Care (POC) meeting and used for assessment and intake, the Support Coordinator (SC) explains to those present the range of services and supports available in the Adult Day Health Care (ADHC) Waiver. Questions are answered as simply and clearly as possible to afford the individual every opportunity to gain a full understanding of program requirements and services. The SC then schedules the face-to-face POC development meeting with the participant and members of his/her support network. The planning team may include anyone requested by the participant but at a minimum will include the individual, his/her representative (if applicable) and the SC. The team may also include members of the individual's family or informal support system, or professional personnel chosen by the individual. A direct service provider or provider representative may participate if that is requested by the individual. Professional service providers may also be included in the care planning process based on the assessment results, when warranted. SCs are trained by OAAS to use person-centered planning methods and tools during initial assessment visits in order to identify those individuals who should participate in the subsequent planning meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A. The Support Coordinator (SC) is responsible for assuring that the initial Plan of Care (POC) is completed timely, reviewed annually, and updated as needed. The SC must conduct a face-to-face POC meeting with the participant and/or legal or responsible representative and members of his/her social and professional supports network or circles of informal supports. Other professionals providing services may be included in the care planning process based on the assessment results, when warranted. The waiver participant may choose his responsible representative and other of his/her choosing to assist in developing the POC. A meeting is scheduled at a time and location that is convenient for the participant. The SC also works with the participant and/or responsible or legal representative and members of his/her social supports network or circles of informal supports to convene subsequent POC update meetings.

POC Time Frames

Initial POCs:

The support coordinator (SC) must contact the participant and/or responsible representative within three (3) business days of receiving the Support Coordination Choice/Release of Information form to schedule a face-to-face assessment.
The SC must conduct a face-to-face intake assessment meeting within seven (7) calendar days of receiving the Support Coordination Choice/Release of Information form to offer Freedom of Choice of provider(s)and explain all available services in the waiver.
The SC supervisor must approve and submit the participant's POC packet within thirty-five (35) calendar days of receiving the Support Coordination Choice/Release of Information form to the data contractor and OAAS Regional Office (RO).
Once the POC packet is approved, the SC must send (via mail, fax or email) the POC packet to the participant and/or responsible representative and the provider(s) on the same day as the POC packet approval. In addition, the SC will contact the participant and/or responsible representative and the provider(s) on the same day as the POC packet approval to notify him/her of the approval.
The provider(s) has ten (10) calendar days from date of approval notification to initiate services.
The SC must contact the participant within ten (10) calendar days from the date of provider service initiation to assure the appropriateness and adequacy of the service delivery.

B. The Minimum Data Set-Home Care (MDS-HC) assessment tool is the comprehensive assessment used to gather information needed to develop the POC. In addition to the MDS-HC, SCs may work with the individual to review and/or obtain other relevant health or psychosocial assessments performed by other service and healthcare providers, for instance hospice or home health agencies. SCs are also trained by OAAS in the use of person-centered assessment techniques in order to ensure that the participant's preferences, goals and risks are addressed in the POC. This will result in a comprehensive POC that addresses all of the participant's needs.

C. Prior to the initial meeting with the SC, the individual is sent a fact sheet describing services under the Adult Day Health Care Waiver. At initial contact upon linkage to the Adult Day Health Care waiver, the support coordinator discusses the availability of all services in the waiver and reviews the freedom of choice form. The freedom of choice forms lists names of local providers enrolled in Medicaid and/or participating in the waiver, and this listing is also available on the OAAS website at: http://new.dhh.louisiana.gov/index.cfm/page/129/n/130. The SC uses this process and the FOC list to assist the individual to choose services and providers.

D. The POC must be outcome-oriented, individualized and time limited (e.g. annual goals and related mile stones). Essential elements of the planning process include:
• Tailoring the POC to the participant's needs based on the on-going use of the participant-focused assessment utilizing the Minimum Data Set-Home Care (MDS-HC).
• Developing mutually agreed upon strategies to achieve or maintain inclusion of participants' desired outcomes, which rely on informal, natural community supports and appropriate formal paid services.
• Assisting the participant to make informed choices about all aspects of supports and services needed to achieve his/her desired outcomes which involves assisting him/her to identify specific, realistic needs and choices.
• Incorporation of steps which empower the participant to develop/enhance independence, growth, self-advocacy and self-
management.
• Language shall be understandable to all parties involved.

E. Coordination of Services

During the assessment and care-planning process, the SC identifies services that are already being received by the participant and documents these on the POC. Depending on the nature of those services, the SC may request and review formal assessments and other documents developed by other provider(s), and any documents that are relevant to the participant's needs, interests, strengths, preferences and desired outcomes. With the participant's input, waiver and/or non-waiver services are planned for and scheduled with existing services in mind and with care to avoid unnecessary or inappropriate duplication of services. The SC may also use person-centered planning tools, such as routines mapping, to identify existing services.

The SC informs the participant and/or his/her responsible representative of all available home and community-based services, as well as other community services outside of Medicaid.

The SC assists the participant to obtain the services identified in the approved POC assuring that they meet the participant's individual needs while assisting to initiate, develop and maintain an informal support network.

Any identified needs are addressed by the SC on the POC and referrals are made to appropriate providers for those needs that are beyond the scope of the ADHC Waiver services.

The SC obtains the participant's authorization to secure appropriate services as detailed in the POC.

F. The SC is responsible for confirming that ADHC services have begun and for monitoring implementation. The SC monitors implementation through monthly phone calls to participants and/or to their legal/responsible representative and through quarterly face-to-face visits, as well as through the Electronic Visit Verification (EVV) system. SC will review ADHC attendance reports from the EVV system on a regular, on-going basis to ensure implementation and service delivery. SC will meet with ADHC Waiver participants and/or legal/responsible representatives at least quarterly to verify, review documentation of service delivery, and/or discuss the same with the participant. Twelve (12) month re-assessments and POC meetings may account for a quarterly or a monthly contact. The documents reviewed to verify service delivery include ADHC attendance logs, progress notes and progress summaries which must be maintained at the ADHC center and EVV attendance reports which are real-time and available via web connection. Participant and representatives are also asked about the accuracy of ADHC attendance logs and whether services are delivered according to the participant's preferred schedule.

Monitoring of ongoing services includes a review of service delivery documentation for the previous calendar quarter including EVV and post-authorization data. The SC performs the following: Discuss the last quarter of service delivery with the participant or responsible representative; Determine whether all ongoing services in the POC were delivered in the amount, frequency, and duration specified in the service plan; If an ongoing service is not delivered according to the POC for the quarter, the SC shall assesses the reason, remediate when applicable and document utilizing the Service Monitoring Codes on the Support Coordination Documentation (SCD) form.

Monitoring whether all types of services were delivered is completed during the final quarter of the POC year or month of discharge, when applicable. The SC performs the following: Determine whether all types of services in the POC were delivered within the POC year and enter the appropriate code for each applicable service; For any service types specified in the POC which were not delivered during the POC year, check the applicable reason code and enter supporting details in the narrative section; If an undelivered service is due to any reason requiring remediation, code as such and perform and document the required remediation activities.

G. How and when the plan is updated, including when the participant's needs change:

POC Changes:

The POC is updated at least annually. In addition, the SCs continuously assess the need to update the POC due to any significant changes in the participant's circumstances or condition.

There are two (2) types of POC Revisions: Routine and Emergency

Routine POC Revisions:

Routine POC Revisions are due within five (5) calendar days from the date of the reported change.

NOTE: Unless a re-assessment was conducted and indicates a change in the participant's condition, then the Routine POC Revision is due fourteen (14) calendar days after the completion date of the re-assessment.

Emergency POC Revisions:

Emergency POC Revisions are due within twenty-four (24) hours from the date of the reported change.

The SCs assess participants and identify factors that put them at risk and affect or may affect their health, and/or welfare throughout their POC year. This ongoing monitoring assesses the effectiveness of the support strategies and identifies changes of the participant's needs or other health and welfare concerns. The frequency and intensity of the monitoring must be adjusted to meet the needs of the participant and corresponds to the level of identified risk. However, the participant, legal and/or responsible representative, provider, or medical practitioner, with a signed consent agreement for communication, can request a POC review at any time when concerns about health and welfare arise. The SC and the provider(s) are responsible for informing the participant to contact the SC of any significant changes in his/her status. A significant change in status may require a re-assessment. A “significant change in status” is an improvement or decline in the participant’s condition that is NOT temporary in nature, i.e., cannot be expected to resolve itself in a short period of time (e.g., 2 weeks).

Participants also may contact their SC at any time and may request a POC review. SCs must respond to participant requests for assistance.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Support coordinators (SCs) and providers assess participants and identify factors that put waiver participants at risk and affect, or may affect, their health and/or welfare through the initial medical certification, and the annual Plan of Care (POC) process using the Minimum Data Set for Home Care (MDS-HC) tool, as well as participant, family and provider input. Ongoing monitoring assesses the effectiveness of the support strategies and identifies changes in the participant's needs, and/or other health and welfare concerns. The frequency and intensity of the monitoring must be adjusted to meet the needs of the participant and corresponds to the level of identified risk.

The MDS-HC includes specific Client Assessment Protocols (CAPs) that are triggered and identified for detailed planning based on the comprehensive assessment. Many of these CAPs address risks common among elders and adults with physical disabilities, such as falls, depression, dehydration, abuse, environmental hazards, etc. Support coordinators are required to address every triggered CAP.

SCs are also required to develop an emergency plan and monitor that it is current and viable.

To ensure participants and providers have continuous access to support coordination, OAAS requires that the SCAs maintain a 24/7 emergency telephone contact number to assist with any emergencies occurring outside of normal business hours.

An Individual Responsibility Agreement (IRA) is used when a participant expresses a desire to take responsibility for certain risks or to leave certain areas of concern unaddressed, such as Client Assessment Protocols (CAPs) that triggered, rather than have the service provider address all risks or areas of concern. Under an IRA, the participant assumes responsibility for certain risks. Use of an IRA is an acknowledgment of the dignity of risk assumed by an individual. An IRA provides documentation, by participant signature that the participant freely chooses to assume the responsibility for an identified risk or area of concern and understands the consequences if the risk or concern goes unaddressed. The SCA will access and care plan for participants on an initial basis, annually, and whenever a significant change in status occurs. A “significant change in status” is an improvement or decline in the participant’s condition that is NOT temporary in nature, i.e., cannot be expected to resolve itself in a short period of time (e.g., 2 weeks). During this time all identified risks and areas of concern must be planned for and defined outcomes identified in the plan of care. The Plan of Care (POC) must document how each identified risk and area of concern is addressed and by whom, including all areas addressed by formal and informal supports. Any unaddressed risk should be closely scrutinized and deliberated by the care planning team. It is strongly recommended that the SCA utilize their RN consultant in conducting such a review. Whenever, in the judgment of the SC, after consulting with the participant, an unaddressed risk poses a serious threat to the participant’s health and welfare and: (1) The resources cannot be found to meet the risk and (2) The participant expresses the preference to take responsibility for, or leave unaddressed, an identified risk, the use of an IRA should be considered.

In instances described above, the SC attempts to mitigate the risk utilizing available non-waiver resources (e.g. community, etc.). If this cannot be accomplished, the SC will collaborate with OAAS RO to determine if an IRA is necessary to ensure health and safety. If an IRA is necessary, a referral is sent to the OAAS Service Review Panel (SRP) who will determine whether an IRA is appropriate. If SRP deems an IRA appropriate, the SC will work with OAAS RO to draft an IRA. After the SC completes the IRA, he/she must forward it to the OAAS RO for review and approval.

The participant must have a clear understanding of the tasks, functions, and supports that the service provider will not perform. When the participant takes responsibility for a risk or concern, he/she must demonstrate how he/she will address the identified risk or concern. When the participant chooses to leave a risk unaddressed, he/she must express understanding of the consequences of leaving the risk unaddressed.

A responsible representative is not allowed to authorize an IRA but may participate in the negotiation process at the discretion of the participant. Only the participant and/or the legally authorized representative are allowed to authorize and sign an IRA. The participant must have the cognitive capacity to make informed decisions and understand what he is signing; OR when participants have a legally authorized representative (i.e., legal guardian, medical power of attorney) this legally authorized representative must participate in negotiating the IRA and must be the one to sign if the participant does not have the cognitive ability to sign.

The IRA identifies the participant, the SC, service provider, provider representative, and legally authorized representative, as applicable, who negotiated the agreement. The IRA includes dated signatures of the participant, legally authorized representative when applicable, provider representative, SC and other parties involved. The IRA identifies the

risk or concern for which the participant agrees to take responsibility. The IRA includes details provided by the participant regarding specific plans to address the risk or concern. The IRA includes a statement describing potential consequences for the participant and notes that these consequences were explained to the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

When the individual is offered the Adult Day Health Care (ADHC) Waiver, he/she may accept or deny the offer. If the individual accepts the offer, he/she chooses a Support Coordination Agency (SCA) through the Freedom of Choice (FOC) process. The data contractor is responsible for facilitating this process.

At initial contact with the participant, the Support Coordinator (SC) discusses the availability of all services in the ADHC Waiver and shares the ADHC provider FOC forms. The ADHC FOC form is a list of all local Medicaid enrolled ADHC providers in the service area. This list is available on the OAAS website at:
http://new.dhh.louisiana.gov/index.cfm/page/129/n/130

The SC encourages the participant and his/her responsible representative to contact and interview the ADHC providers that he/she is interested in, in order to make an informed choice.

The SC is responsible for advising the participant that changes in ADHC providers can be requested at any time, but only by the participant and/or responsible/legal representative. SCs must at each annual Plan of Care (POC) meeting remind participants that they may change ADHC providers. Any request for a change requires a completion of an ADHC provider FOC form. The SC is responsible for supplying the participant with a current listing of ADHC providers.

Alternative methods of communication are used as the situation arises. There are two (2) main ways to provide language services: oral and written language services (interpretation and translation, respectively) and have substantial flexibility in determining the appropriate mix and medium. Where needed, Braille type mediums and interpretive services can be provided.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Through an Interagency Agreement (IA) with the Operating Agency (OAAS), the Medicaid agency (BHSF) has delegated approval of Plans of Care (POCs) to OAAS. This is done to assure that OAAS is complying with all HCBS regulations related to service planning, is following the Adult Day Health Care (ADHC) Waiver application requirements and is identifying areas of deficiency on the POCs and implementing appropriate corrective actions.

BHSF receives reports specific to the ADHC Waiver which facilitate BHSF's oversight of the service plan approval processes. MPSW reviews current performance reports, determines need for new activities concerning quality and oversight in waiver programs and ensures adequate remediation enforcement.

The following Operations Reports are generated quarterly from the data contractor database: Program enrollment, LOC redeterminations, service plan timeliness, service utilization and made available directly to BHSF and OAAS.

During the POC development process, SCs are responsible for ensuring that all of the participant's health and welfare needs are addressed in the POC. If a SC is unable to fully address the participant's health and welfare needs in the POC, a referral is submitted to the OAAS Regional Office (RO)/OAAS Service Review Panel (SRP). The OAAS RO and SRP reviews and makes the final determination as to whether the participant's health and welfare needs can be met in the ADHC Waiver. OAAS monitors participant's health and welfare through the annual support coordination monitoring process (See performance measure D.a.i.a.1 and D.a.i.a.2). OAAS submits this performance measure and remediation information, along with SRP health and welfare referral outcomes annually to BHSF.

Mortality Reports are generated by OAAS from the Medicaid Eligibility database, critical incident reporting database and public health vital records database annually and are submitted to BHSF.

Critical Incident Trend Reports are generated by OAAS quarterly from the critical incident reporting database and are submitted to BHSF (See Appendix G: Quality Improvement).

Support Coordination Agency Monitoring Report is generated by OAAS from the Support Coordination Agency Monitoring database annually and submitted to BHSF (See Appendix D: Quality Improvement).

These reports are reviewed and acted upon by the Medicaid HCBS Oversight Committee which meets at least quarterly and is composed of representatives from the DHH Program Offices and BHSF.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☒ **Operating agency**

☒ **Case manager**

☒ **Other**
Specify:

ADHC provider

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Support Coordinator (SC) is responsible for monitoring the implementation of the Plan of Care (POC) and the participant's health and welfare.

The SC must contact the participant within ten (10) calendar days from the date of provider service initiation to assure the appropriateness and adequacy of the service delivery.

The SC monitors the approved services at least quarterly. This ongoing monitoring assesses the effectiveness of the support strategies and identifies changes in the participant's needs or other health and welfare concerns. The frequency and intensity of monitoring must be adjusted to meet the needs of the participant.

The SC may make unannounced visits to verify that the participant is receiving the services based on the schedule of the approved POC. The SC must conduct a monthly telephone call to the participant to ensure that services are being provided in accordance with the approved POC.

For ADHC Waiver participants with in-home Medicaid State plan personal care services, the SC conducts at least two (2) quarterly face-to-face visits at the ADHC center and two (2) face-to-face visits in the participant's home (or more frequently, if necessary). For ADHC Waiver participants without in-home Medicaid State plan personal care services, the SC conducts at least three (3) quarterly face-to face visits at the ADHC center and one (1) face-to-face visit in the home (or more frequently, if necessary). At these face-to-face visits, the SC evaluates the effectiveness of the support strategies and will make appropriate POC Revisions, as needed. Additionally, the SC meets with members of the planning team on an as needed basis to identify and address issues that affect the participant's health and welfare. The SC submits POC Revisions to the DHH/OAAS Regional Office.

During the monthly and/or quarterly contacts, the SC will assess whether the participant:

• Had problems receiving services as written in the Plan of Care (POC);
• Had problems with goals being met;
• Had problems with his/her preferences being respected, (i.e. services being delivered at his/her preferred times);
• Had problems accessing non-waiver health care services;
• Had problems getting a backup worker when a worker did not report to work as scheduled (if applicable);
• Had falls, injuries, hospitalizations, been restrained, or been a victim of verbal abuse, physical abuse, neglect, or exploitation;
• Had a substantial change in his/her medical condition;
• Had a substantial change in the ability to do things for himself/herself;
• Had an identified need for an EAA or assistive device(s);
• Had a change in non-paid caregivers or living situation;
• Had a change in who will assist him/her in the event of an emergency; and
• Had a change in medications/treatments and/or who gives them.

SCs are responsible for prompt follow-up and remediation of problems identified during participant contacts. Follow-up and remediation activities are documented in the Support Coordination Documentation (SCD). The SCDs are part of the information reviewed by OAAS during the annual representative sample record review as described in the Quality Improvement section of this appendix.

In instances when a Support Coordination Agency (SCA) is unable to remediate problems with service plan implementation or health and welfare, they contact the OAAS Regional Office (RO) staff who offer technical assistance until a problem has been resolved. When issues cannot be resolved at the RO level, the RO submits a referral to the Service Review Panel (SRP) with possible recommendations. SRP maintains records of decisions related to Plan of Care (POC) implementation and this data is shared with the both the OAAS Quality Review Team and OAAS Executive Management when problems are identified which require systemic improvement.

Upon first becoming aware of alleged abuse, neglect, exploitation or extortion, OAAS RO, SCAs and service providers report directly and immediately to Adult Protective Services (APS) who is responsible for investigating these incidents (as described in Appendix G-1.). Additionally, Support Coordinators (SCs) and service providers are required to report, address and track critical incidents (as described in G-1.b.). Final resolution of all critical incidents is through the OAAS RO staff in collaboration with the SCAs. The RO or its designee makes a final determination of when all necessary follow-up for health and welfare is complete.

The SC is the entity responsible for monitoring the implementation of the service plan and the participant's health and welfare. The Quality Review Team will review quality data and information on a quarterly basis as part of operational reviews and will make recommendations for systemic improvement to the OAAS Executive Management Team. The OAAS Executive Management Team will consider all recommendations by the OAAS Quality Review Team and will authorize actions on quality initiatives to address problems identified. This process is described in greater detail in Appendix H-1.a.i. The SC monitors the implementation of the service plan and the participant's health and welfare through monthly phone calls and quarterly face-to-face contacts. The monitoring information is recorded utilizing the Support Coordination documentation (SCD) Protocol and the critical incident management system. If problems are identified, the SC reports it/them to his/her supervisor for assistance with resolution. If the problem cannot be resolved within the SCA, then RO staff is contacted for assistance. Appendix G-1.d describes the collaboration between SCs and RO in critical incident resolution. The process for changing providers is described in Appendix D-1-f.

The SCD requirements include three (3) major areas:
1. Contact and Service Monitoring Information (includes types of contact and service activities and remediation codes);
2. Participant Questions (includes risk assessment questions); and
3. Support Coordination Actions (includes actions taken to address any noted areas of concerns in the risk assessment).

These requirements:
1. provide a guide for asking all of the required, key questions for monthly and quarterly contacts;
2. provide a structured format to gain comprehensive information and effectively coordinate care and services;
3. provide a format for the collection of information which covers many review elements of the OAAS quality assurance monitoring; and
4. prompt SCs to ask appropriate questions and use critical thinking to ensure continual monitoring and POC Revisions to reflect the participant's current status.

The SCD includes risk assessment questions which prompts the SCs to reassess and update the POC, the emergency plan, and the back-up staffing plan (if applicable).

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk***

factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.a.1 Number and percent of participants who had service plans that addressed their needs (including health care needs) as indicated in the assessment(s). Percentage = Number of participants who had service plans that addressed their needs (including health care needs) as indicated in the assessment(s) / Total number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.i.a.2 Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessment(s). Percentage = Number of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessment(s) / Total number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% + or - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
D.a.i.a.3 Number and percent of participants whose service plans addressed their personal goals as indicated in the assessment(s). Percentage = Number of participants whose service plans address their personal goals as indicated in the assessment(s) / Total number of participants reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% + or - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.i.a.4 Number and percent of participants with emergency plans which have been agreed to by the responsible parties. Numerator = Number of participants with emergency plans which contained an agreement signature by the responsible parties Denominator = Total number of participants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.i.a.5 Number and percent of participants with staffing back-up plans which have been agreed to by the responsible parties. Numerator = Number of participants with staffing back-up plans which contained an agreement signature by the responsible parties; Denominator = Total number of participants reviewed.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.c.1 Number and percent of participants whose service plans were updated as warranted, on or before waiver participants' annual review date. Numerator = Number of participants whose service plans were updated as warranted, on or before waiver participants' annual review date; Denominator = Total number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Medicaid data contractor data systems

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Medicaid data contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.i.c.2 Number and percent of waiver participants whose service plans were reviewed and revised as needed to address changing needs. Numerator = Number of waiver participants whose service plans were reviewed and revised as needed to address changing needs; Denominator = Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.d.1 Number and percent of participants who received all types of services

specified in the service plan. Percentage = Number of participants who received all types of services specified in the service plan / Total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid data contractor data systems

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Medicaid data contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.i.d.2 Number and percent of participants who received services in the scope, amount, frequency and duration specified in the service plan. Percentage = Number of participants who received services in the scope, amount, frequency and duration specified in the service plan / Total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid data contractor data systems

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Medicaid data contractor		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.e.1 Number and percent of waiver participants with a valid signature, defined as the participant's/authorized representative's signature, on the service plan which verifies that freedom of choice was offered among waiver providers. Numerator = Number and percent of waiver participants with a valid signature on the service plan; Denominator = Total number of participants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.i.e.2 Number and percent of waiver participants with a valid signature, defined as the participant's/authorized representative's signature, on the service plan which verifies that a list of waiver services was provided to and discussed with the waiver participant. Numerator = # of participants with a valid signature on the service plan; Denominator = # of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

For all performance measures except D.a.i.c.1, D.a.i.d.1 and D.a.i.d.2 OAAS regional office staff perform monitoring of support coordination agencies at least annually utilizing the OAAS Support Coordination Monitoring Tools: Participant Interview, Participant Record Review, Support Coordinator Interview, and Agency Review. The sample size will be large enough for a confidence level of 95% and will be designated on the first day of each waiver year. The number of participants from the statewide sample to be included in each support coordination agency (SCA) sample will be proportional to the percentage of participants linked to each agency on the first day of each waiver year. A SCA's sample size will be determined separately for each region in which the SCA operates.

For all performance measures except D.a.i.c.1, D.a.i.d.1 and D.a.i.d.2., the specific criteria for these measures are found in the OAAS Interpretive Guidelines for the OAAS Participant Record Review.

D.a.i.c.1 measures the first part of sub-assurance c., whether the service plan was updated at least annually or when warranted. The Medicaid Data contractor is responsible for prior authorization of services and authorizes services based upon receipt of an approved service plan. Data is then entered into the contractor data system which provides 100% representativeness for this measure.

D.a.i.c.2 measures the second part of sub-assurance c., whether service plans are updated when warranted by changes in the waiver participant's needs. The data source is the OAAS Participant Record Review and the responsible party for data collection/generation is the operating agency.

Regarding D.a.i.d.1 and D.a.i.d.2: the Medicaid data contractor prior authorizes services according the approved service plan and enters post authorization of service once a provider has verified service delivery. This data is utilized to determine whether the participant received the type, scope, amount, duration, and frequency specified in the service plan. The SMA and the Operating agency review the quarterly reports for these measures.

Regarding D.a.i.e.1 and D.a.i.e.2: a valid signature on the service plan is either the signature of a participant with the capacity to approve the plan or a person who has been designated on the OAAS Authorized Representative Form as such.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The State's method for addressing individual problems identified through performance measures D.a.i.c.1., D.a.i.d.1., D.a.i.d.2 is as follows:

D.a.i.c.1: The OAAS Regional Office receives quarterly reports from the Medicaid Data Contractor for review. If the participant's annual Plan of Care (POC) was not submitted within the required timeline, the Regional Office will contact the support coordination agency. The support coordination agency will have 10 days to correct the discrepancies. If the corrections are not made within the timeframe, and depending upon the scope and persistence of such problems, OAAS may pursue sanctions as outlined in the Support Coordination Performance Agreement including withholding payment.

D.a.i.d.1: The OAAS Regional Office receives quarterly reports from the Medicaid Data Contractor in order to review trends and patterns of under-utilization of services. If this appears to be an isolated event, the Regional Office will follow up with the support coordination agency to determine the reason and the support coordinator shall revise the POC as necessary. If the POC revision is not submitted within the time frame, OAAS shall pursue sanctions as outlined in the Support Coordination Performance Agreement. If this appears to be widespread, the Regional Office will consult with State Office staff who will then bring the issue to the OAAS Quality Review Team and, if necessary, OAAS Executive Management for review and resolution.

D.a.i.d.2: The OAAS Regional Office receives quarterly reports from the Medicaid Data Contractor in order to review trends and patterns of under-utilization of services. If the regional office discovers under-utilization due to a particular agency, among certain services, lack of availability of services, etc., the Regional Office will consult with State Office staff who will then bring the issue to the OAAS Quality Review Team and, if necessary, OAAS Executive Management for review and resolution.

The remediation activities for these three measures will be documented in a spreadsheet by the regional office.

The State's method for addressing individual problems identified through the remaining performance measures is as follows: Regional Office staffs perform monitoring of Support Coordinator Agencies (SCA) at least annually utilizing the OAAS Support Coordination Monitoring Tools: Participant Interview; Participant Record Review; Support Coordinator Interview; and Agency Review. The processes for scoring and determining the necessity for corrective actions are located in the Support Coordination Agency Monitoring Policy and Procedures Manual. After all elements are assessed and scored, the Regional Office reviewer documents the findings, including the Statement of Determination which delineates every POC remediation required and required responses/plans of correction expected from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. The Regional Office and/or State Office follow-up according to timelines associated with each level to ensure that plans of correction are implemented and effective. Level III determinations are those having the actual or potential to immediately jeopardize the participant's health and safety. In these cases, the SCA must develop a plan of correction that includes the identification of the problem; full description of the underlying causes of the problem; actions/interventions that target each underlying cause; responsibility, timetable, and resources required to implement interventions; measurable indicators for assessing performance; and plans for monitoring desired progress and reporting results. In addition, OAAS takes immediate enforcement action to assure the health and safety of participants. Actions include, but are not limited to: transfer of participants who are/may be in jeopardy; removal of SCA agency from the freedom of choice list; suspension of all new admissions; financial penalties; and suspension of contract/certifications as a provider of SC services.

If a Plan of Correction, Progress Report and/or Follow-up Report remains unapproved by the time of the next annual review the agency placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.

Training will be necessary when trends are detected in plans of care that do not address: participant goals, needs (including health care needs), and preferences; how waiver and other services are coordinated; and identification of responsibilities to implement the plan. The training requirements depend on the Support Coordination Monitoring findings and are based on the criteria found in the OAAS Interpretive Guidelines for the OAAS Participant Record Review.

An unsatisfactory plan of care is one with criteria "not met" according to the OAAS Interpretive Guidelines for

the OAAS Participant Record Review.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied,

suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Louisiana Medicaid Eligibility Manual (MEM) states, “Every applicant for, and enrollee of, Louisiana Medicaid benefits has the right to appeal any agency action or decision, and has the right to a fair hearing of the appeal in the presence of an impartial hearing officer." (Medicaid Eligibility Manual, T-100/Fair Hearings/General Information).

Both applicants and participants are afforded the right to request a fair hearing for services which have been denied, not acted upon with reasonable promptness, suspended, terminated, reduced or discontinued, La. R.S. 46:107. A person may file an administrative appeal to the Division of Administrative Law (DAL) section regarding the following determinations:

1. Denial of entrance into a home and community-based service waiver;
2. Involuntary reduction or termination of a support or service;
3. Discharge from the system; and/or
4. Other cases as stated in office policy or as promulgated in regulation.

During the initial assessment process, which must begin within seven (7) calendar days of referral/linkage of the participant to the Support Coordination Agency (SCA), the Support Coordinator (SC) will give a participant and/or his/her legal representatives an OAAS information sheet entitled “Rights and Responsibilities for Applicants/Participants of a Home and Community-Based Services Waiver” which includes information on how to file a complaint, grievance, or appeal.

The SC and/or RO are responsible for giving written adverse action notices to the individual and/or his/her legal representatives of how to contact the DAL section.

BHSF utilizes the Home and Community-Based Services (Waiver) Medicaid Decision notice to notify individuals by mail if they have not been approved for a Home and Community-Based Services Waiver due to financial ineligibility. Page two (2) of this notice includes "Your Fair Hearing Rights". This page contains information on how to request a fair hearing and a section to complete, if the individual is requesting a fair hearing. This written adverse action notice to the waiver participant indicates that this decision is a Medicaid decision. If the participant does not return this form, it does not prohibit his right to appeal and receive a fair hearing.

In accordance with 42 CFR 431.206, 210 and 211, participants receiving waiver services, and their legal representatives are sent a letter by OAAS Regional Office (RO) providing at least ten (10) days advance and adequate notification of any proposed denial, reduction, or termination of waiver services. Included in the letter are instructions for requesting a fair hearing, and notification that an oral or written request must be made to the Division of Administrative Law (DAL) on or before the date of the proposed adverse action by the RO in order for current waiver services remain in place during the appeal process. If the appeal request is not made to DAL on or before the date of the proposed adverse action, but is made within thirty (30) days from the date of the notice, the action is taken pending final outcome of the appeal. If the final decision of the Administrative Law Judge (ALJ) is favorable to the appellant, services are re-implemented from the date of the final decision. An appeal hearing is not granted if the appeal request is made later than thirty (30) days following the date of the notice sent by RO. Once a request for an appeal is received, DAL notifies RO of the appeal request. A copy of the letter and the appeal request is kept in the participant’s record at the appropriate RO. A final decision must be rendered within ninety (90) calendar days of the appeal request.

In the event of an appeal request, if requested by the participant and/or legal representative, the SC will provide documentation (e.g. progress notes, etc.) and information that may be necessary to complete the appeal or prepare for a fair hearing. In addition, at a fair hearing, the SC will participate by telephone.

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing. The appellant may contact the DAL directly, or may request withdrawal through the RO. Requests for withdrawal are kept in the participant’s record at the appropriate RO.

All administrative hearings are conducted in accordance with the Louisiana Administrative Procedure Act, La. R.S. 49:950 et seq. Any party may appear and be heard at any appeals proceeding through an attorney at law or through a designated representative.

OAAS will provide MPSW with quarterly reports of those individuals who have been notified of appeal rights when waiver services have been denied, terminated or reduced, reasons for the appeal and the outcome of the appeal.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Health Standards Section (HSS) is responsible for operating a HCBS complaint line to address complaints concerning all DHH/HSS licensed waiver providers. OAAS is responsible for addressing complaints concerning Support Coordination Agencies (SCAs).

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For purposes of this application, the words "complaints" and "grievances" are used interchangeably.
DHH does not restrict the types of grievances that participants may register. In the Rights and Responsibilities form that every participant receives is the telephone number of the OAAS Help Line and the HSS complaint line to call in complaints.

1. HSS retains responsibility for licensing those waiver providers for whom licensing is required. Their complaint process is described below:

It is the policy of HSS to assess, report, investigate and follow-up on all complaints involving licensed waiver providers. HSS will investigate and/or refer complaints to the appropriate agency relative to a participant not receiving care and/or treatment for which he/she is entitled under State or Federal laws. Investigations occur as soon as possible after intake. Complaints are triaged into two (2), ten (10) or thirty (30) days depending on the severity of the allegation. When deficiencies are cited relative to the complaint investigation, the provider is required to submit a plan of correction within ten (10) working days. After the plan of correction is reviewed and determined acceptable, a provider is given up to sixty (60) days to implement corrective action. A revisit is conducted either on-site or by desk review to verify that the plan of correction has been implemented.

The length of time for deficiencies to be cited is dependent upon when the survey is completed. A complaint triaged as immediate jeopardy (to initiate investigation within two (2) working days) will have deficiencies written sooner than one triaged as a thirty (30) day complaint. If a thirty (30) day triage is assigned, the HSS field office has thirty (30) days from the date of the complaint intake to enter the provider agency. If it is found that the client is indeed in an immediate jeopardy situation, HSS will require a plan of removal so that the immediacy of the situation is removed for the client and imminent peril or harm no longer exists. This is different from a plan of correction for deficiencies that may be cited. When an incident has occurred, the provider agency is responsible for doing its own internal investigation. If HSS also receives a complaint, then HSS is required by law to investigate. In cases of abuse or neglect involving home and community-based services, Adult Protective Services also investigates. HSS receives copies of all these reports and if there is anything regulatory involved, may initiate a complaint investigation.

2. OAAS retains responsibility for certifying OAAS Support Coordination Agencies (SCAs). OAAS requires SCAs to have a grievance process that allows all participants to freely voice any and all complaints. A copy of the SCA complaint and/or grievance process is provided to each participant. The SCA must first investigate to determine if the participants' complaints can be resolved internally. The SCA is responsible for working with the participant regarding the complaint. If the participant is not satisfied with the SCA's resolution, the SCA is required to notify OAAS. It is the policy of OAAS to immediately assess, report, investigate and follow-up on all complaints about SCAs involving OAAS waiver participants as soon as they are received. The participant may also report any complaints regarding their SCA to OAAS.

All participants are informed that filing a grievance or making a complaint is not a pre-requisite or substitute for a fair hearing.

OAAS staffs a Help Line that gives participants the ability to file any and all other complaints not related to licensed service providers or SCAs.

By establishing the complaint system identified above, the participants, Support Coordinators (SCs), providers, and general public have a means by which to report any and all complaints that may influence the care or services a participant receives.

All complaints involving abuse, neglect, exploitation and extortion of waiver participants must immediately be forwarded to APS, and/or law enforcement, as appropriate, and copied to DHH state and ROs through the critical incident management system. The providers and/or SCAs must cooperate with external agencies: Adult Protective Services (APS), and law enforcement, by providing relevant information, records, and access.

OAAS State Office (SO) staff works collaboratively with OAAS Regional Offices (RO) to review complaints and assess whether any changes to policies, procedure, etc. are warranted based on the findings. Additionally, through annual SCA Agency Review Monitoring, OAAS staff ensures that SCAs are documenting complaints and following the policies set forth by each individual agency in accordance with OAAS requirements.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

It is the policy of OAAS to assess, investigate, report, and follow-up on all critical incidents involving all Adult Day Health Care (ADHC) Waiver participants. When an event is considered critical, the provider must immediately ensure the health and welfare of the participant and complete a DHH HCBS Critical Incident Report. The provider and/or the support coordination agency must report critical incidents within two (2) hours of first knowledge of the incident. The provider is required to complete and submit the HCBS Critical Incident Report within 24 hours of discovery of the incident and must provide an update to the Support Coordination Agency within 3 working days.

Types of OAAS critical incidents or events that must be reported include:

A. Major Injury - any suspected or confirmed wound or injury to a person of known or unknown origin which requires treatment by a physician, dentist, nurse, or other licensed health care provider.

B. Major Medical Event - an occurrence in which the participant receives a medical procedure by a physician, nurse practitioner, dentist, or other licensed health care provider either during an inpatient or outpatient visit, and a new diagnosis is identified or new orders for medications, servgices, (such as Home Health), therapy, equipment, health-related tasks, or treatments are prescribed.

C. Death - all deaths of participants are reportable, regardless of the cause or the location where the death occurred.

D. Fall - when the person is (1) found down on the floor (un-witnessed event) or (2) comes to rest on the floor unintentionally, whether or not the person is being assisted at the time.

E. Major Medication Incident - means the administration of medication in an incorrect form, not as prescribed or ordered, or to the wrong person, or the failure to administer a prescribed medication, which requires treatment by a physician, nurse, dentist or any licensed health care provider. Medication errors may be due to the following:

1. Staff error - the staff fails to administer a prescribed medication, or administers the wrong medication or dosage to a person;
   staff failure to fill a new prescription order within 24 hours or a medication refill prior to the next ordered dosage.
2. Pharmacy error - the pharmacy dispenses the wrong medication and/or dose or provides inaccurate or inappropriate administration
   directions.
3. Participant error - the person unintentionally fails to take his/her medication as prescribed.
4. Family error - a family member intentionally or unintentionally fails to administer a prescribed medication or fails to fill a new
   prescription order.

F. Major Behavioral Incident - the occurrence of an incident that can reasonably be expected to result in harm or may affect the safety and well being of the person. The following are examples of major behavioral incidents: attempted suicide, suicidal threats, self endangerment, elopement, self injury, and physical aggression. Offensive sexual behavior and sexual aggression are considered reportable if it is a new behavior which is not addressed in the POC, or if there has been an increase in the intensity or frequency of the behavior.

G. Involvement with Law enforcement resulting in participant's arrest

H. Participant is a victim of crime

I. Loss or Destruction of Home - damage to or loss of the participant's home that causes harm or the risk of harm to the participant. This may be the result of any action, man-made or natural. Examples include fire, flooding, eviction, unsafe or unhealthy living environment.

Protective Services Critical incidents shall be reported by any person having cause to believe that an adult's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, exploitation, or extortion shall report to the adult protection agency or to law enforcement. (Louisiana Revised Statute 14:403.2)

Types of Protective Services critical incidents or events that must be reported include:

A. Abuse

1. Physical - contact or actions that result in injury or pain, such as hitting, pinching, yanking, shoving, pulling hair, etc.
2. Emotional - threats, ridicule, isolation, intimidation, harassment
3. Sexual abuse of an adult, when any of the following occur:
   a. the adult is forced, or otherwise coerced by a person into sexual activity or contact,
   b. the adult is involuntarily exposed to sexually explicit material, sexually explicit language, or sexual activity or contact;
   c. the adult lacks the capacity to consent, and a person engages in sexual activity or contact with that adult.

B. Neglect
1. Care Giver - means withholding or not assuring provision of basic necessary care, such as food, water, medical, or other support services, shelter, safety, reasonable personal and home cleanliness or any other necessary care.
2. Self - means failing, through one's own action or inaction, to secure basic essentials such as food, medical care, support services,shelter, utilities or any other care needed for one's well-being.

C. Exploitation - the misuse of someone's money, services, property, or the use of a power of attorney or guardianship for one's own purposes

D. Extortion - taking something of value from a person by force, intimidation, or abuse of legal or official authority.

The direct service provider must report critical incidents, including abuse & neglect, within 2 hours of first knowledge of the incident. Incidents of abuse, neglect, exploitation and extortion must be reported to the support coordinator and to Adult Protective Services (APS). When an incident is discovered by the support coordinator (SC), the SC must contact the DSP within 2 hours of discovery. When abuse, neglect, exploitation or extortion is discovered by the SC, the SC must contact APS.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The participant and/or his/her responsible representative are given information pertaining to abuse, neglect, and exploitation by review of the Rights and Responsibilities form with the support coordinator at the initial, and annual meetings.

The APS toll-free telephone number for persons to report abuse, neglect, or exploitation are printed on the Rights and Responsibilities form, and the DHH website.

The purpose of the OAAS Help Line is to provide a central point of communication in Louisiana for individuals inquiring about all aspects of home and community-based services. It also provides a central point to contact DHH about incidents involving services, personal treatment, health, and welfare. The OAAS Help Line telephone number is printed on the Rights and Responsibility form, and appears on the DHH/OAAS website.

OAAS Regional Office (RO) telephone numbers are also provided to the participants and the public to inquire about all aspects of home and community-based services and to provide information about incidents involving services, personal treatment, health, and welfare.

In relation to critical incidents, the Rights and Responsibilities form explains that participants have the right to be treated with dignity and respect and to be free from abuse, neglect, exploitation, restraints, and seclusion. This form provides the telephone number to report suspected cases of abuse, neglect and exploitation. This form also explains that individuals have the responsibility to report critical incidents including, abuse, neglect, exploitation, or extortion, to their support coordinator and direct service provider immediately. It further explains that the support coordinator should be made aware of any of the following changes: health, medications and physical condition and that he/she will assist in reporting and resolving critical incidents.

Support coordinators are required to educate individuals during initial and annual POC meetings on the information described above.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The responsibility for review of and response to critical incidents is a collaboration between Direct Service Providers (DSP)/ADHC providers, Support Coordinators (SCs) and OAAS Regional Office (RO) staff with OAAS assuming the primary responsibility for assuring that all health and welfare follow-up has been accomplished. OAAS regional office staff monitors the progress of each incident and the work of the SC and the DSP provider to ensure each incident report is complete and submitted timely. Once the RO staff verifies the completeness of the report, the regional manager or designee conducts their review and makes the final determination as to whether all appropriate actions have been taken to protect the participant from harm, to ensure all medical or other services were provided, and that the service plan identifies possible measures to prevent or mitigate the recurrence of similar critical incidents. The responsibilities are further delineated as follows:

A. DSP Provider responsibilities:

1. Take immediate action to assure the participant is protected from further harm and respond to any emergency needs of the participant;
2. Report incidents involving abuse, neglect, exploitation, and extortion to APS.
3. Notify the support coordination agency within two (2) hours of discovery of the occurrence of the critical incident.
4. Cooperate with the investigation/incident and provide all necessary information/documentation, at a minimum, by close of the third business day after the initial report;
5. Submit updates to the support coordination agency regarding the critical incident, as necessary, until resolution, including, at a minimum, at least one update submitted by the close of the third business day of the initial report;
6. Participate in any planning meetings convened to resolve the critical incident or to develop strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future;
7. In the event of falls, conduct a fall assessment using the OAAS Fall Assessment Form and submit with initial Critical Incident report; subsequently conduct a fall analysis and complete the OAAS Fall Analysis and Action Form and submit with Follow-up information; and
8. Track critical incidents to identify remediation needs and quality improvement goals and to determine the effectiveness of the strategies employed.

B. Support Coordination Agency (SCA) responsibilities:

1. Take immediate action to assure the participant is protected from further harm and respond to any emergency needs of the participant;
2. When the incident is discovered by the SC, contact the DSP provider when necessary;
3. Report incidents involving abuse, neglect, exploitation, and extortion to APS as appropriate.
4. Enter critical incident report information into the DHH critical incident reporting database by close of business the next business day after notification of a critical incident;
5. Enter follow-up case note by close of the sixth business day after initial report;
6. Continue to follow up with the DSP provider, the participant, and others, as necessary, and update the DHH critical incident reporting database with case notes until the incident is resolved and the case is closed;
7. Convene any planning meetings that may be needed to resolve the critical incident or develop strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future and revise the POC accordingly;
8. Send the participant and DSP provider a copy of the Incident Participant Summary within fifteen (15) days after Final Supervisory Review and Closure by the RO. It does not include the identity of the Reporter or any sensitive or unsubstantiated allegations. The Participant Summary is not distributed in the event of deaths;
9. In the event of falls, ensure that a fall assessment is conducted using the OAAS Fall Assessment Form and a fall analysis using the OAAS Fall Analysis and Action Form; reviews analysis and collaborates with the DSP provider and natural supports to implement preventative strategies.

10. Track critical incidents to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies
employed.

C. OAAS Regional Office Manager (or designee) responsibilities:

1. On a daily basis, review all new critical incidents including APS cases. Determine priority level (urgent or non-urgent) of cases
and assign to regional office staff. Priority is based on the information received, the severity of the incident, when the incident
occurred, and when the incident report was received. The OAAS Regional Office (RO) staff determines whether the incident is Urgent
or Non-Urgent. Investigation will be prioritized as follows:
-Urgent - any event or situation that creates a significant risk of substantial harm to the physical or mental health, safety, or
well being of a waiver participant;
- Non-urgent - all other events/situations
2. Alert staff members of urgent cases within one business day of receipt of the incident and take appropriate action;
3. Review and approve extension requests made by RO staff (extensions may be granted up to 30 days at a time). Extensions should not
exceed 90 days unless it is an APS case in which case extensions should not exceed 150 days.
4. Assure that all mandatory fields are entered into the LDH critical incident reporting database prior to case closure;
5. Close cases after all needed follow-up has occurred and all necessary data has been entered into the LDH critical incident reporting
database (Final Supervisory Review and Closure).
6. Track critical incidents to identify remediation needs and quality improvement goals and to determine the effectiveness of
strategies employed.

D. OAAS Regional Office Staff responsibilities:

1. Continue to follow up with the support coordination agency, provide technical assistance, and request additional information in
writing as necessary until closure of the critical incident;
2. Make timely referrals to other agencies as necessary;
3. Assure that all necessary information is entered into the LDH critical incident reporting database by support coordination agency;
4. Assure that activities occur within required timelines, including closure of the incident within 30 days unless an extension has
been granted;
5. Submit requests for extensions to the Regional Manager for review and approval;
6. Assure that the Incident Participant Summary is completed on all cases, including APS cases; and
7. Identify participants who experience frequent critical incidents and work with the SCA to identify and develop strategies to
mitigate risk.

The following agencies may be requested to assist and/or respond to critical incidents:

- APS for incidents regarding abuse, neglect, and/or exploitation. and or extortion of participants age 18 and older;
- Attorney General when incidents are determined valid following an investigation by OAAS and/or another agency;
- Law enforcement for incidents involving allegations of sexual and/or physical abuse and suspected criminal activity;
- DHH Program Integrity for incidents related to billing irregularities.

Appropriate action means that the participant is protected from harm, all medical or other services were provided and that the service plan identifies possible measures to prevent or mitigate the recurrence of similar critical incidents. These actions are further delineated under Appendix G-1.d.

Please refer to G-1.d section B.8:
Send the participant and DSP provider a copy of the Incident Participant Summary within fifteen (15) days after Final Supervisory Review and Closure by the RO.

The required timeline including closure of the incident is 30 days unless an extension has been granted as described in Appendix G-1.d.

As defined in the OAAS Critical Incident Policy (OAAS-ADM-10-020), the definition of an extension is: Additional time allowed for completion and closure of a critical incident. Extensions are approved by the Regional Manager or designee when additional time is needed to respond to the incident. Primary examples include hospitalizations, temporary admission to a long term care facility, or awaiting an APS report. Extensions shall not be granted for more than 30 days at a time. Extensions should not exceed 90 days with the exception of APS cases in which extensions shall not exceed 150 days.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

OAAS shall collaborate with DSP providers, support coordination agencies and APS to ensure the implementation of critical incident procedures to accomplish the following goals:

A. Assure that the participant is protected from further harm and that medical or other services are provided, as needed.
B. Complete incident report and assure that the information is entered and monitored in the DHH critical incident reporting database.
C. Continue to follow-up to determine the cause and details of the critical incident.
D. Convene the participant's support team, when appropriate, to review the Plan of Care (POC)/service plan to identify possible measures to prevent or mitigate the re-occurrence of similar critical incidents.
E. Revise the POC/service plan, as indicated, and monitor the effectiveness of the revised plan.
F. Close the critical incident in the critical incident management system.
G. Inform the participant and other relevant parties of the investigation results.

APS Cases

A. Incidents involving abuse, neglect, extortion, or exploitation of participants age 18 and older are reported to APS. Incidents accepted by APS are investigated and entered into the critical incident reporting database by APS. APS is responsible for investigations involving non-licensed individuals and DHH's Health Standards Section (HSS) is responsible for investigations involving licensed providers. RO cooperates with the investigation. Upon APS closure the case is transferred to RO to complete any actions or recommendations to assure health and welfare. Upon closure by the RO, the participant is sent a summary of the incident.

OAAS State Office responsibilities:

1. Provide technical assistance to RO staff, as needed.
2. Identify statewide needs for training regarding: (a) response to critical incidents; (b) adherence to the critical incident policy; (c) correct entry of critical incident data; (d) tracking critical incidents; (e) using data for remediation and/or quality enhancement; and (f) other related topics.
3. During the Support Coordination Monitoring Record Review process, a statistically valid sample of critical incidents are reviewed for adherence to policy, analysis of actions taken to address/resolve the critical incident, analysis of non-resolved cases, and other pertinent issues as determined. Following the monitoring period, State Office staff analyzes the monitoring data to identify areas in need of reinforcement, technical assistance, and remediation.
4. Aggregate critical incident data quarterly and analyze the data to identify trends and patterns.
5. Generate and review reports of the trends and patterns to identify potential quality enhancement goals.
6. Conduct an annual analysis of data to determine the effectiveness of quality enhancement goals and activities.

Medicaid provides oversight of critical incident management through the Medicaid HCBS Oversight Committee which meets quarterly to review current performance reports for all waiver assurances including Health and Welfare.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

DHH/OAAS informs participants of their right to be free from restraints and seclusion through the Rights and Responsibilities form. Support Coordinators(SC) are trained by OAAS to identify, detect, and regularly monitor for evidence of use of restraints and seclusion. They are also trained to help participants explore alternatives to the use of restraints and how to properly report suspected use.

The SC monitors participants through monthly telephone contact and quarterly face-to-face contacts to ensure that these rights are maintained. During OAAS' annual Support Coordination Monitoring, OAAS staff confirms that SCs both monitor and address any identified instances of restraints in accordance with OAAS policy through its annual record review process. Oversight of other licensed providers is conducted through DHH's Health Standards Section (HSS).

The DHH/OAAS Adult Protective Services (APS) toll free line and critical incident reporting process provides mechanisms for reporting, communicating, and responding to violations of these rights.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

DHH/OAAS informs participants of their right to be free from restrictive interventions through the Rights and Responsibilities form. Support Coordinators(SC) are trained by OAAS to identify, detect, and regularly monitor for evidence of use of restrictive interventions. They are also trained to help participants explore alternatives and how to properly report suspected use.

The SC monitors participants through monthly telephone contact and quarterly face-to-face contacts to ensure that these rights are maintained. During OAAS' annual Support Coordination Monitoring, OAAS staff confirms that SCs both monitor and address any identified instances of restrictive interventions in accordance with OAAS policy through its annual record review process. Oversight of other licensed providers is conducted through DHH's Health Standards Section (HSS).

The DHH/OAAS Adult Protective Services (APS) toll free line and critical incident reporting process provides mechanisms for reporting, communicating, and responding to violations of these rights.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DHH/OAAS informs participants of their right to be free from seclusion through the Rights and Responsibilities form. Support Coordinators(SC) are trained by OAAS to identify, detect, and regularly monitor for evidence of participant seclusion. They are also trained to help participants explore alternatives and how to properly report suspected use.

The SC monitors participants through monthly telephone contact and quarterly face-to-face contacts to ensure that these rights are maintained. During OAAS' annual Support Coordination Monitoring, OAAS staff confirms that SCs both monitor and address any identified instances of participant seclusion in accordance with OAAS policy through its annual record review process. Oversight of other licensed providers is conducted through DHH's Health Standards Section (HSS).

The DHH/OAAS Adult Protective Services (APS) toll free line and critical incident reporting process provides mechanisms for reporting, communicating, and responding to violations of these rights.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices

(e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

- ○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.i.a.1. Number and percent of abuse, neglect, exploitation, and unexplained death investigations that included evidence of effective resolution and preventative measures. Numerator = Number of investigations that included evidence of effective resolution and preventative measures; Denominator = All investigations completed and transferred to waiver staff

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.i.b.1 Number and percent of critical incident reports that were completed within required time frames as specified in the approved waiver. Numerator = Number critical incident reports that were completed within required time frames as specified in the approved waiver; Denominator = Total number of critical incidents reports.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.i.b.2 Number and percent of participants with a valid signature, defined as the participant's/authorized representative's signature, on the service plan which verifies receipt of information about how to report critical incidents as specified in the approved waiver. Numerator = # of participants with a valid signature on the service plan; Denominator= Total # of participants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.i.c.1 Number and percent of participants with a valid signature, defined as the participant's/authorized representative's signature, on the service plan which verifies receipt of information on how to remain free from restraints and seclusion. Numerator=Number with a valid signature on the service plan which verifies receipt of information; Denominator=Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.i.d.1 Number and percent of participants who received the coordination and support to access health care services identified in their service plan. Numerator = Number of participants who received the coordination and support to access health care services identified in their service plan; Denominator = Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

It is the policy of OAAS to assess, investigate, report, and follow-up on all critical incidents involving all Adult Day Health Care Waiver participants. When an event is considered critical, the direct service provider (DSP) and/or support coordinator will be required to immediately ensure the health and welfare of the participant and will be required to complete the DHH HCBS Critical Incident Report Form. The DSP and/or the support coordination agency will be required to report critical incidents within two (2) hours of first knowledge of the incident.

In reference to G.a.i.a.1, OAAS State Office staff will review each finalized Adult Protective Services (APS) investigation after it is transferred to OAAS Regional Office staff and closed. This review will confirm whether each incident included evidence of effective resolution and preventative measures as recommended by APS.

In reference to G.a.i.b.1, the required timeline, including closure of the incident, is 30 days unless an extension has been granted as described in Appendix G-1-d. As defined in the OAAS Critical Incident Policy OAAS-ADM-10-020. The DSP or support coordinator must report critical incidents, including abuse & neglect, within 2 hours of first knowledge of the incident. The OAAS Regional Office staff is responsible for monitoring each incident to make sure that it is closed timely and complete.

Regarding G.a.i.b.2, G.a.i.c.1, and G.a.i.d.1: OAAS regional office staff perform monitoring of support coordination agencies at least annually utilizing the OAAS Support Coordination Monitoring Tools: Participant Interview, Participant Record Review, Support Coordinator Interview, and Agency Review. The sample size will be large enough for a confidence level of 95% and will be designated on the first day of each waiver year. The number of participants from the statewide sample to be included in each support coordination agency (SCA) sample will be proportional to the percentage of participants linked to each agency on the date the sample is generated. A SCA's sample size will be determined separately for each region in which the SCA operates.

Regarding G.a.i.b.2, G.a.i.c.1, The Rights and Responsibilities Form informs participants of: (1) Their right and responsibility to report critical incidents to their support coordinator and DSP and of their right to report suspected abuse, neglect and exploitation by calling Adult Protective Services and (2) Their right to remain free from all types of restraints and seclusion. The support coordinator provides information to the participant which aids in identifying restraint use and seclusion and also provides instruction for the participant to report this to their support coordinator. The support coordinator will then provide technical assistance and implement alternative measures that are the least restrictive to the participant (e.g. personal assistance devices, DME, etc.). The support coordinator reviews this information with the participant and/or authorized representative each year during the plan of care development meeting. A valid signature on the service plan is either the signature of a participant with the capacity to approve the plan or a person who has been designated on the OAAS Authorized Representative Form as such.

Regarding G.a.i.d.1, during the record review process OAAS Regional Office staff review monthly support coordination documentation to ensure that each participant was provided appropriate and sufficient coordination and support to access health care services identified in the service plan.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The State's method for addressing individual problems identified through the performance measure G.a.i.a.1 and G.a.i.b.1 are as follows:

The OAAS regional managers are responsible for remediation of all critical incidents and investigations that were not completed within required time frames or according to policy. Regarding G.a.i.a.1, if any critical incidents lacked evidence of effective resolution and inclusion of preventative measures as recommended by APS, the Regional Manager will be notified, technical assistance provided, and instructions will be given to correct each occurrence. Regarding G.a.i.b.2, regional managers receive quarterly incident closure reports generated from the critical incident database. Any incident investigation not completed within the required time frame will be completed no later than the end of the quarter following that in which it was due. Concerning timely incident closure, the regional managers will analyze the report for their regions quarterly and work with regional staff, direct service providers (DSPs), and support coordination agencies to remediate current deficiencies and improve future performance. The regional managers also have the responsibility to notify the regional program operations manager and/or division director of noncompliance trends identified within their region including problems with providers who are non-responsive to technical assistance and guidance. Any systemic remediation needs identified are presented to the OAAS Quality Review Team for resolution.

The State's method for addressing individual problems identified through the performance measures G.a.i.b.2, G.a.i.c.1, and G.a.i.d.1 are as follows:

Regional Office staff perform monitoring of Support Coordinator Agencies (SCA) at least annually utilizing the OAAS Support Coordination Monitoring Tools: Participant Interview; Participant Record Review; Support Coordinator Interview; and Agency Review. The processes for scoring and determining the necessity for corrective actions are located in the Support Coordination Agency Monitoring Policy and Procedures Manual. After all elements are assessed and scored, the Regional Office reviewer documents the findings, including the Statement of Determination which delineates every remediation required with the POC and required responses/plans of correction expected from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. The Regional Office and/or State Office follow-up according to timelines associated with each level to ensure that plans of correction are implemented and effective. If a Plan of Correction, Progress Report and/or Follow-up Report remains unapproved by the time of the next annual review the agency placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Louisiana Department of Health and Hospitals (DHH) utilizes a collaborative approach to develop and maintain its Quality Improvement Strategy (QIS). Louisiana's Medicaid agency, the Bureau of Health Services Financing, Medicaid Program Support and Waivers (BHSF/MPSW) Section, oversees the implementation of home and community-based services (HCBS) waivers. The Office of Aging and Adult Services (OAAS) is the operating agency for the Adult Day Health Care Waiver. All Support coordination agencies are certified and sign a performance agreement with OAAS. Through this agreement, OAAS oversees and monitors each agency's performance as it relates to performing level of care assessments, developing and approving service plans, and ensuring the health and welfare of waiver participants. All of the above mentioned entities also work collaboratively with Adult Protective Services, DHH's Health Standards Section (HSS), and/or law enforcement agencies as deemed necessary. The process of trending, prioritizing and implementing system improvement activities are required on all levels with upward reporting to the operating agency for oversight and management of the Quality Improvement Strategy including a summary of root cause analysis completed at each level and recommendations for design changes or other system improvements. This approach provides opportunities for continued communication and review of performance measures, discovery data, and remediation activities.

The Quality Improvement Strategy (QIS) for the Adult Day Health Care Waiver is part of a cross-waiver function of OAAS and the Office for Citizens with Developmental Disabilities (OCDD). Additionally, beginning in 2014 with the renewal of the Community Choices Waiver (LA.0866.R01.00), OAAS began utilizing composite sampling and consolidated evidence reporting across its two aging and adult disability waivers in accordance with CMS' quality memo "Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers" released in 2014. These changes served to streamline monitoring, remediation, and reporting for both waivers and resulted in increased efficiency to discovery methods and implementing systemic improvements.

The purpose of the QIS is to assess and promote the quality of waiver programs serving elders and adults with physical, intellectual and developmental disabilities. The QIS assures a consistent and high standard of quality across DHH's waiver programs through:

- Adoption of common standards and performance measures against which waiver programs are evaluated.
- Development of policies, tools, practices, training, protocols, contracts and agreements that embody sound approaches to managing, delivering and assessing home and community-based services and supports. To the extent possible, HCBS waiver policies and practices have shared purposes, language, and expectations.
- Streamlining and consolidating functions to strengthen the collection and analysis of timely and reliable data on waiver performance.
- A transparent system of reporting performance data for use by program managers, policymakers, consumers, providers, and other stakeholders.
- A structured and coordinated process to identify improvement opportunities, set priorities, allocate resources, and implement effective strategies.
- A coordinated approach for evaluating the effectiveness of the QIS in meeting program goals.

DHH has a multi-tiered system for quality improvement. Each level (Direct Service Providers, Support Coordination Agencies, OAAS, and BHSF) is required to design and implement a Quality Management Strategy which is further described below.

Direct Service Provider and Support Coordination Agency Processes:

Direct Service Provider and Support Coordination Agencies are required to have a Quality Management Strategy that includes collecting information and data to learn about the quality of services, analyzing and reviewing data to identify trends and patterns, prioritizing improvement goals, implementing the strategies and actions on their quality enhancement plan, and evaluating the effectiveness of the strategies. At a minimum, providers and SC agencies must review: 1) critical incident data, 2) complaint/grievance data, and 3) interview/survey data from participants and families. The review process must include review by internal review team(s) composed of agency programmatic and management staff.

OAAS Processes:

Aggregate data for waiver performance indicators are analyzed on a quarterly basis by OAAS Quality and Program Operations staff. The review of this data allows OAAS to routinely assess the performance of support

coordination agencies, require remediation/corrective action plans (when appropriate), and to monitor the status of remediation activities. In addition to the aggregate state-level analysis, performance measure data is also analyzed across the nine service regions of the state and for each support coordination agency. This targeted analysis allows OAAS to determine whether any substandard performance is occurring on a systemic, statewide level or is localized to a particular region or agency(ies) and facilitates remediation efforts. Upon completion of the analysis, a summary report is presented to the OAAS Quality Review Committee (QRC). The QRC's membership includes OAAS Executive Management staff and managers from OAAS' Policy, Program Operations, and Research and Quality Management divisions. The QRC reviews the report and, in response to needs identified in the analysis, makes recommendations for changes in policies, procedures, and the QIS as needed. When significant changes are proposed to the QIS, OAAS allows stakeholders to review and provide input. Recommendations, performance indicator data reports, and quality improvement initiatives status reports are submitted to BHSF/MPSW on a quarterly basis.

BHSF/MPSW Processes:

Medicaid/Program Offices Quarterly Meeting – This group convenes at least quarterly to perform executive level oversight of the performance of HCBS waivers, assure their effectiveness and efficiency, and discuss any other programmatic issues common to the program offices and Medicaid. Goals are to act upon issues and recommendations received from the Medicaid HCBS Oversight Committee and other HCBS workgroups. This meeting is a forum for executive level problem resolution, planning, and development of quality redesign strategies. Members include representatives from MPSW, the Medicaid Director or Deputy Director, the OAAS Assistant Secretary or Deputy Assistant Secretary, and other designated staff.

Medicaid HCBS Oversight Committee – meets at least quarterly with the specific purpose to ensure proper oversight of DHH's HCBS waiver programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs, and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Oversight members include HCBS quality management staff from MPSW and OAAS and are chaired by the MPSW Section Chief or designee. The committee meets at least quarterly with the following standing agenda items:

- OAAS operating agency staff present their analysis of all performance measure findings, remediation activities, and systemic improvements to MPSW as defined in the 1915(c) waiver QIS
- MPSW Section Chief or designee indicates approval or disapproval of quarterly/annual data and activities;
- Based on evidence presented, MPSW staff provides technical assistance, guidance, and support to the operating agency staff;
- MPSW performs administrative oversight functions for OAAS HCBS programs.
- MPSW/OAAS/Medicaid Data Contractor Meetings – facilitates monthly meetings with OAAS and the Medicaid data contractor to discuss waiver issues, problems, and situations which have arisen that do not align with program policy. At these meetings, solutions are formulated, corrective actions are agreed upon, and follow-up implemented by OAAS as necessary in the form of internal policy or provider policy.

Ad Hoc Cross-Population HCBS Oversight Meetings – Additional meetings will be held jointly between MPSW, OAAS, and OCDD on an as needed basis for the following purposes:
- Collaborate on design and implementation of a comprehensive system of cross-population continuous quality improvement
- Present Quality Improvement Projects (QIP)
- Share ongoing communication of what works, doesn't work, and best practices.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: Medicaid HCBS Oversight Committee	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

OAAS Process:

Following system design changes, data on performance indicators are reviewed by the Waiver and Quality program staff, as well as the OAAS Quality Review Committee to assure that the information is useful and accurate and to determine if performance has improved. Input is sought, as appropriate, from Support Coordination and Direct Service Provider Agencies, participants and their families, and other stakeholders, to determine whether the system design change is helping to improve efficiency, effectiveness, and overall quality of waiver supports and services.

BHSF/MPSW Processes:

Medicaid HCBS Oversight Committee – meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS waiver programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs, and ensure adequate monitoring of remediation activities. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Oversight members include HCBS quality management staff from MPSW and OAAS and the committee is chaired by the MPSW Section Chief or designee. The committee meets at least quarterly with the following standing agenda items:
-OAAS staff present their analysis of all performance measure findings, remediation activities, and systemic improvements to MPSW as defined in the 1915(c) waiver QIS
-MPSW Section Chief or designee indicates approval or disapproval of quarterly/annual data and activities;
-Based on evidence presented, MPSW staff provides technical assistance, guidance, and support to the operating agency staff;
-MPSW performs administrative oversight functions for OAAS HCBS waiver programs.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The BHSF/MPSW Section works in collaboration with the operating agency, OAAS, to periodically review the QIS. Meetings are held to review and evaluate performance indicators, discovery methods, remediation strategies, systemic issues, policies, procedures and other issues that surface as a result of monitoring activities. Technical assistance is provided to the operating agency as needed by the BHSF/MPSW Section.

OAAS' Quality Review Committee meets at least quarterly and provides ongoing oversight and management of the QIS.
OAAS routinely conducts Participant Experience Surveys to gain first-hand information on participants' experience with and satisfaction of their HCBS. OAAS aggregates findings to identify areas of concern in service delivery in order to improve policies, procedures, and the QIS. New priority projects may be identified to better align the QIS to the needs of OAAS staff, support coordinators and providers and, most importantly, to improve desired outcomes for HCBS waiver participants.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ○ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

All Medicaid providers will be required to fulfill the requirements under the provision of the Single Audit Act to maintain Medicaid enrollment. Medicaid staff will ensure that any provider receiving the amount of funds specified in the Single Audit Act will be required to provide a copy of the independent audit for continued Medicaid enrollment on an annual basis. Disenrollment will occur as a result of non-compliance.
Program Integrity's Surveillance and Utilization Review (SUR) Unit is responsible for conducting post-payment reviews of all fee-for-service Medicaid providers. The post-payment review process used by the Program Integrity Section within the Louisiana Department of Health and Hospitals(DHH) is described in the Louisiana Surveillance and Utilization Review Subsystem (SURS) Rule and the Medical Assistance Program Integrity Law (MAPIL).
Sources for cases come from complaints, referrals (internal and external) and data mining (regularly scheduled data runs and ad hoc data runs). Complaints are received via mail, fax, email, website, hotline, etc. A team made up senior analysts and a supervisor triages all complaints. Onsite visits are determined on a case by case basis and depends on the severity of the complaint. The SURS data mining team produces computer runs that generate open cases. Providers whose income spikes from one period to another are identified through exception processing and will generate case openings.

Post-payment reviews are triggered when potential fraud, waste and abuse is identified either through a complaint, referral or data mining. SURS opens complaint cases throughout the year after the triage process. Some data mining runs (such as SURGE or Spike runs, date of death runs, outlier runs, etc.) are done on a fixed schedule. Other data mining runs are done on an ad hoc basis where project cases are opened and are usually policy-focused. For example, providers billing for in-home services while the recipients are hospitalized.

SURGE Run is a computer run that is produced on a regular basis that identifies providers that meet a set of criteria and/or conditions. The run looks for providers with incomes that surge.

Enrolled providers are divided by regions established by the Louisiana Department of Health and Hospitals(DHH). The computer runs are done by region. There are a total of 10 computer runs. There are 9 in-state runs and 1 out-of-state run. Runs are done on a monthly basis with the exception of the month of June and December. Providers are selected based on 3 criteria: location, amount paid and percent change in amount paid.
•First, a provider must be located in the region that is being reviewed.
•Secondly, a provider must have generated a minimum dollar amount paid in a 12 month period to be included for processing.
•And finally, a provider must have had a "surge" in income from a six month period in one year to a six month period in another year.

A variety of professional staff are used to perform fraud, waste and abuse reviews. Analysts conducting the reviews are primarily Registered Nurses; however, there are dental hygienists and social workers on staff. In addition to the analysts, professional consultants are utilized such as physicians with different specialties, dentists, etc. Complaints are sent to the triage team, which is made up of professional staff that screen complaints for fraud, waste and abuse. If fraud, waste and abuse is involved, further research is done to determine if a comprehensive or focused review is done. Referrals are also made to professional licensing boards, local law enforcement, the Medicaid Fraud Control Unit (MFCU), child/adult protection, DHH program managers, etc. All SURS cases are worked by a professional staff analyst.

Once the review is completed by the analyst, the Quality Assurance (QA) team reviews the findings closely. Also, during the review process, medical consultants may give input as well as the Program Integrity Director and DHH program managers. After the case has completed the QA process, the findings of the review are also reviewed by the RN Supervisors. From there, the correspondence to provider detailing the results of the audit is presented by the RN Supervisors to the Program Integrity Director and manager. After the findings letter is sent, the provider is entitled to an informal hearing as well as an appeal hearing and judicial review. Once the review findings have been confirmed and finalized, any overpayments due are collected.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State*

financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.a.i.a.1 # and % of waiver claims coded & paid for in accordance with the reimbursement methodology specified in the approved waiver application and only for those services rendered. Numerator=# of waiver claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver application and only for those services rendered; Denominator= Total # of claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MPSW Tracking System

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.a.i.b.1. Number and percentage of rate changes that are approved by MPSW and consistent with the CMS approved rate methodology. Numerator=Number of rate changes approved by MPSW and consistent with the CMS approved rate methodology; Denominator = Total number of rate changes.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Data Warehouse

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

I.a.i.a.1.
BHSF determines all waiver payment amounts/rates in collaboration with OAAS, Division of Health Economics, and as necessary the Rate & Audit section. At the time of each requested rate change, MPSW and the Rate and Audit section reviews evidence that the rate adjustment was applied according to the methodology described in the waiver document. When a rate adjustment proposal is submitted without documentation which supports the current methodology it will not be approved and MPSW will offer technical guidance.

I.a.i.b.1
Upon annual review and analysis of all waiver claims payments through Medicaid Data Warehouse report generation, any discrepancies are resolved individually and systemically in collaboration with Medicaid Information Management Systems staff who oversee the Fiscal Intermediary.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

DHH has the ultimate responsibility for determining the rates for the Adult Day Health Care(ADHC) Waiver services. DHH does not allow differences in the rates for different providers of the same waiver services.

- ADHC: The methodology for calculating each individual component of the overall ADHC rate is a product of the median cost multiplied by an index factor as approved by legislation detailed in LAC 50.XXI.2915. The resultant calculations provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ADHC services. The base rate is calculated using the most recent audit or desk review cost for all ADHC providers filing acceptable full year cost reports and includes the following components:

a. Direct care;
b. Care related costs;
c. Administrative and operating costs;
d. Property/capital costs; and
e. Transportation costs

Because of the wide variation in transportation cost, which is influenced by the rural or urban location of the ADHC center and the number of participants using the ADHC's transportation services versus other means of transportation (e.g. transportation provided by family, etc.), the transportation component of ADHC reimbursement is calculated and paid individually to each ADHC center.

Rates for the other services provided under the ADHC waiver are based on the following:

- Support Coordination: The Support Coordination rate is the same as is paid to support coordination providers to other DHH HCBS waivers targeted to the elderly and adult onset disability population. The support coordination agencies typically serve individuals in all waivers targeting this population.

-Transition Intensive Support Coordination: The Intensive Support Coordination rate is comparable to the Transition Intensive Support Coordination (TISC) services in other DHH HCBS waivers targeted to the elderly and people with adult onset disability population for the same reason stated above.

-Transition Services: The Transition Service one-time fee is based upon the total amount of funding available divided by the one-time fee of $1,500 to determine the number of transitional participants to serve. This cap was set based on the historical cost allowed for providing the service in other waivers. Transition Services are not factored into the participant's budget.

No rate can be implemented without the approval of the Medicaid Agency (BHSF). The Medicaid Rate Setting and Audit Section manages annual reimbursements made under various long term care reimbursement methodologies for Medicaid recipients receiving long term care services such as ADHC.

The reimbursement methodology is included in the Medicaid rulemaking process. This rulemaking process includes opportunity for public comment from providers/provider groups, program participants, advocates, and DHH representatives.

Payment rates are available to participants through the OAAS and Medicaid websites. Participants may also obtain this information through provider agencies, support coordination agencies, and through publication in the Louisiana Register (the official journal for the state of Louisiana).

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Billings for waiver services provided to participants in the waiver program are submitted first to the Medicaid data contractor for prior and post authorization. After services are authorized, providers bill directly to the Medicaid fiscal intermediary for payment.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Eligibility of payments for individuals is verified by the prior and post authorization process performed by the Medicaid data contractor. Prior to authorizing services for payment, the contractor confirms that the participant is eligible for Medicaid waiver services. Once this is confirmed, the services are authorized in the following ways:

1. The services as prescribed in the approved Plan of Care (POC) are entered into the prior authorization system.
2. Upon the provision of services to the participant, the provider submits the service utilization data for post authorization to verify that services were delivered in the scope, duration, and frequency as specified in the approved POC.
3. The post authorization entity checks the service utilization record against the participants approved POC which identifies the prior authorized services.
4. Services provided to participants that are not listed on the prior authorization system are rejected and ineligible for payment until all discrepancies are resolved.
5. The provider then submits claims for approved services to the fiscal intermediary for adjudication and payment.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ( ) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may

voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	12038.00	12997.00	25035.00	38149.00	5086.00	43235.00	18200.00
2	12198.49	13387.00	25585.49	39293.00	5086.00	44379.00	18793.51

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
3	12361.70	13789.00	26150.70	40472.00	5086.00	45558.00	19407.30
4	12527.34	14202.00	26729.34	41686.00	5086.00	46772.00	20042.66
5	12695.00	14628.00	27323.00	42937.00	5086.00	48023.00	20700.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	935	935
Year 2	935	935
Year 3	935	935
Year 4	935	935
Year 5	935	935

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay is based on the total number of days of waiver eligibility of all Adult Day Health Care waiver participants divided by the number of unduplicated participants over the waiver plan year.

Average length of stay is based on the FY-16 Adult Day Health Care waiver 372 report.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D estimates are computed by multiplying the number of users for each service times the average units per user times the average cost per unit for each service available in the waiver. Each service cost is then summed and divided by the total unduplicated count of individuals served in the waiver year.

Individual waiver service users are calculated by taking the recipient number for each service divided by the total unduplicated waiver participants from the FY16 372 report to calculate a percentage of recipients that use the service. The percentage is then applied to the estimated total unduplicated participants (item J-2a).

Average units per user was calculated using the 372 report, the report provides a breakdown by procedure code. Total units for an individual service was divided by the number of recipients utilizing that service to calculate the average units per user. For example, the estimated average ADHC units per user was calculated by dividing the total ADHC units utilized in the FY16 report by the number of unduplicated recipients who utilized ADHC services (2,939,540/693=4242).

Unduplicated number of participants(B-3.a)was calculated as the number of participant at any point in time (B-3.b) plus a factor for attrition/enrollment.

A growth factor of 1.5% was added to ADHC utilization.

ii. ***Factor D' Derivation.*** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' estimates are based on the FY-16 Adult Day Health Care waiver 372 report.

Factor D' reflects the average cost of non-waiver services that would be otherwise furnished to waiver participants. All figures are based on the actual expenditures for services provided in state fiscal year 2016. Prescription drug costs associated with the dual eligible participants are not contained in the report on which factor D' calculations are based.

Based on analysis back to FY12, a 3% increase was then added to each year's estimates.

iii. ***Factor G Derivation.*** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G estimates are based on the FY-16 Adult Day Health Care waiver 372 report. Included in the results were the actual expenditures for all institutional services provided to those recipients for levels of care covered by the approved Adult Day Health Care waiver.

Based on analysis back to FY12, a 3% increase was then added to each year's estimates.

iv. ***Factor G' Derivation.*** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' estimates are based on the FY-16 Adult Day Health Care waiver 372 report.

Factor G' reflects the average cost of non-facility services that would be otherwise furnished to participants. All figures are based on the actual expenditures for services provided in state fiscal year 2016. Prescription drug costs associated with the dual eligible participants are not contained in the report on which factor G' calculations are based.

Based on analysis back to FY12, no inflation or increase in utilization was added to future years.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed*

separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Adult Day Health Care	
Support Coordination	
Transition Intensive Support Coordination	
Transition Service	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						9953112.00
Adult Day Health Care	15 minutes	876	4370.00	2.60	9953112.00	
Support Coordination Total:						1296400.00
Support Coordination	monthly	926	10.00	140.00	1296400.00	
Transition Intensive Support Coordination Total:						1256.00
Transition Intensive Support Coordination	monthly	4	2.00	157.00	1256.00	
Transition Service Total:						4500.00
Transition Service	per service	3	1.00	1500.00	4500.00	
GRAND TOTAL:						11255268.00
Total Estimated Unduplicated Participants:						935
Factor D (Divide total by number of participants):						12038.00
Average Length of Stay on the Waiver:						317

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						**10103433.60**
Adult Day Health Care	15 minutes	876	4436.00	2.60	**10103433.60**	
Support Coordination Total:						**1296400.00**
Support Coordination	monthly	926	10.00	140.00	**1296400.00**	
Transition Intensive Support Coordination Total:						**1256.00**
Transition Intensive Support Coordination	monthly	4	2.00	157.00	**1256.00**	
Transition Service Total:						**4500.00**
Transition Service	per service	3	1.00	1500.00	**4500.00**	
				GRAND TOTAL:		**11405589.60**
				Total Estimated Unduplicated Participants:		**935**
				Factor D (Divide total by number of participants):		**12198.49**
				Average Length of Stay on the Waiver:		317

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						**10256032.80**
Adult Day Health Care	15 minutes	876	4503.00	2.60	**10256032.80**	
Support Coordination Total:						**1296400.00**
Support Coordination	monthly	926	10.00	140.00	**1296400.00**	
Transition Intensive Support Coordination Total:						**1256.00**
Transition Intensive Support Coordination	monthly	4	2.00	157.00	**1256.00**	
				GRAND TOTAL:		**11558188.80**
				Total Estimated Unduplicated Participants:		**935**
				Factor D (Divide total by number of participants):		**12361.70**
				Average Length of Stay on the Waiver:		317

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Service Total:						**4500.00**
Transition Service	per service	3	1.00	1500.00	**4500.00**	
			GRAND TOTAL:			**11558188.80**
			Total Estimated Unduplicated Participants:			**935**
			Factor D (Divide total by number of participants):			**12361.70**
			Average Length of Stay on the Waiver:			317

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						**10410909.60**
Adult Day Health Care	15 minutes	876	4571.00	2.60	**10410909.60**	
Support Coordination Total:						**1296400.00**
Support Coordination	monthly	926	10.00	140.00	**1296400.00**	
Transition Intensive Support Coordination Total:						**1256.00**
Transition Intensive Support Coordination	monthly	4	2.00	157.00	**1256.00**	
Transition Service Total:						**4500.00**
Transition Service	per service	3	1.00	1500.00	**4500.00**	
			GRAND TOTAL:			**11713065.60**
			Total Estimated Unduplicated Participants:			**935**
			Factor D (Divide total by number of participants):			**12527.34**
			Average Length of Stay on the Waiver:			317

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be*

completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						**10568064.00**
Adult Day Health Care	15 minutes	876	4640.00	2.60	**10568064.00**	
Support Coordination Total:						**1296400.00**
Support Coordination	monthly	926	10.00	140.00	**1296400.00**	
Transition Intensive Support Coordination Total:						**1256.00**
Transition Intensive Support Coordination	monthly	4	2.00	157.00	**1256.00**	
Transition Service Total:						**4500.00**
Transition Service	per service	3	1.00	1500.00	**4500.00**	

GRAND TOTAL:	**11870220.00**
Total Estimated Unduplicated Participants:	**935**
Factor D (Divide total by number of participants):	**12695.00**
Average Length of Stay on the Waiver:	317